ApiFix MID-C System Coding Reference Guide

THE INTERNAL BRACE OPTION

Indications For Use: The ApiFix MID-C System is indicated for use in patients with adolescent idiopathic scoliosis (AIS) for treatment of single curves classified as Lenke 1 (thoracic major curve) or Lenke 5 (thoracolumbar/lumbar major curve), having a Cobb angle of 35 to 60 degrees which reduces to less than or equal to 30 degrees on lateral side-bending radiographs, and thoracic kyphosis less than 55 degrees as measured from T5 to T12. Use of the MID-C System in patients with curves of lower magnitudes (i.e., less than 40 degrees) is based on the risk for curve progression.

Humanitarian Device. Authorized by Federal law for use in the treatment of adolescent idiopathic scoliosis (AIS) under Humanitarian Use Exemption H170001. The effectiveness of this device for this use has not been demonstrated.

CAUTION: Federal law restricts this device to sale by or on the order of a physician.

NOTE: This reference table identifies commonly reported codes associated with posterior arthrodesis and deformity correction procedures and may not be exhaustive. It is for informational purposes only. Final coding for any surgical intervention will be dependent on the specific services rendered to the patient as established as medically necessary and documented in the patient's record and determined by the provider entity. As no specific CPT®[1] code describes the complete implantation of the MID-C System, final coding for the procedure is at the discretion of the provider. Providers are encouraged to contact their payer entity, the American Medical Association, the Centers for Medicare or Medicaid Services, or Professional Coding or Medical Society for specific coding assistance. ApiFix does not provide coding guidance or guarantee that payment will be made.

CPT® CODING

Table 1. Commonly Reported Posterior Deformity Correction Physician CPT® Coding

CPT® Code	Description
Proximal Instrumentation Fixation (polyaxial screws and extender rod)	
22800	Arthrodesis, posterior, for spinal deformity, with or without cast; up to 6 vertebral segments (levels)
+22840	Posterior non-segmental instrumentation (e.g., Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation)
+22842	Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments
+22843	Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral segments
MID-C Dynamic Rod Implantation	
22899	Unlisted procedure, spine
22612	*Crosswalk Code: Arthrodesis, posterior or posterolateral technique, single interspace; lumbar (with lateral transverse technique, when performed)
Placement of Graft Material	
20930	Allograft, morselized, or placement of osteopromotive material, for spine surgery only
20931	Allograft, structural, for spine surgery only
20936	Autograft for spine surgery only; local
20937	Autograft for spine surgery only; morselized (through separate skin or fascial incision)
20938	Autograft for spine surgery only; structural bicortical or tricortical (through separate skin or fascial incision)

Unlisted Procedure CPT® Codes

While it may be appropriate to use CPT® 22899 to represent implantation of the ApiFix system, this does not imply anything about coverage or payment for this service. When this "unlisted" CPT® code is submitted, third-party payers typically make a determination regarding payment for the service based on what was performed and the medical necessity of the service. Consideration may also be given to including a "crosswalk" code that is representative of the time and intensity involved in the procedure.

Crosswalk Coding

Crosswalk codes are Category I CPT® codes that can be referenced when submitting a claim for any given unlisted CPT® code. Since unlisted CPT® codes do not have embedded physician work and practice expense values, a crosswalk CPT code representative of the procedure performed can serve as a helpful proxy to characterize the work and practice expense associated with performing the Apifix procedure. Physician work can be quantified in terms of time and intensity.

- **Time:** The time the physician spends with the patient on the day of the procedure before, during, and after the procedure is completed
- **Intensity:** Comprised of three intensity/complexity measures:

– The mental effort and judgment necessary with respect to the amount of clinical data that needs to be considered, the amount of knowledge required, the range of possible decisions, the number of factors considered in making a decision, and the degree of complexity of the interaction of these factors.

– The technical skill required with respect to knowledge, training, and actual experience necessary to perform the service and physical effort involved to perform the service.

– Psychological stress related to pressure involved when the outcome is heavily dependent upon skill and judgment and an adverse outcome has serious consequences.

Practice expense includes general overhead costs and specific expenses incurred in performing the procedure, including:

- Clinical staff time
- Equipment
- Supplies

When using a crosswalk code, it is suggested providers also submit a progress note that accompanies the service and a separate narrative description of the service that includes an explanation of why an unlisted procedure CPT® code was used. In that narrative, providers may also note another CPT® code that is not an unlisted procedure CPT® code and does have a value assigned to it in that third party payer's fee schedule. This may be followed by a suggestion that the service represented by this other CPT® code is similar to the service that was performed. This is often referred to as a crosswalk code. This crosswalk code submitted with claims for payment of the implantation of the ApiFix system should represent a service that is comparable in time, effort, intensity, risk, and decision-making to the implantation of the ApiFix system.

Potential Crosswalk Code for the Apifix Procedure

The service associated with CPT® code 22612 is comparable in time, effort, intensity, risk, and decision-making to the implantation of the ApiFix system. When submitting a claim for payment of implantation of the ApiFix system to a third-party payer, providers may choose to use CPT® 22612 as a crosswalk code, suggesting that the payer use the value it assigns to CPT® 22612 in determining its payment for implantation of the ApiFix system.

HOSPITAL INPATIENT ICD-10-PCS CODING

Effective October 1, 2022, the following new ICD-10-PCS codes were implemented by the Centers for Medicare and Medicaid Services (CMS) to specifically describe the surgical implantation of the MID-C deformity correction system. In addition to this new ICD-10-PCS code for the MID-C system, hospitals are to separately report the appropriate ICD-10-PCS code(s) to describe the spinal fusion performed at the non-instrumented segment of the spine. The fusion code(s) are reported separately in addition to the ICD-10-PCS code for the Mid C System implantation assigned by CMS.

Table 2. Hospital Inpatient ICD-10-PCS Coding[2]
Implantation of MID-C System

X New Technology **N** Bones **S** Reposition			
Body Part	**Approach**	**Device**	**Qualifier**
Ø Lumbar Vertebra **4** Thoracic Vertebra	**Ø** Open **3** Percutaneous	**C** Posterior (Dynamic) Distraction Device	**7** New Technology Group 7

Table 3. Hospital Inpatient ICD-10-PCS Coding[2]

Posterior Arthrodesis

Ø Medical and Surgical
R Upper Joints
G Fusion

Body Part	Approach	Device	Qualifier
6 Thoracic Vertebral Joint **7** Thoracic Vertebral Joints, (2 to 7) **A** Thoracolumbar Vertebral Joint	**Ø** Open **3** Percutaneous	**7** Autologous Tissue Substitute **J** Synthetic Substitute **K** Nonautologous Tissue Substitute	**1** Posterior Approach, Posterior Column

Ø Medical and Surgical
R Lower Joints
G Fusion

Body Part	Approach	Device	Qualifier
Ø Lumbar Vertebral Joint **1** Lumbar Vertebral Joints, (2 or more)	**Ø** Open **3** Percutaneous	**7** Autologous Tissue Substitute **J** Synthetic Substitute **K** Nonautologous Tissue Substitute	**1** Posterior Approach, Posterior Column

Table 4. Medicare Severity-Diagnosis Related Group (MS-DRG)[3]

MS-DRG	Description
456	Spinal Fusion Except Cervical with Spinal Curvature, Malignancy, Infection or Extensive Fusions with MCC
457	Spinal Fusion Except Cervical with Spinal Curvature, Malignancy, Infection or Extensive Fusions with CC
458	Spinal Fusion Except Cervical with Spinal Curvature, Malignancy, Infection or Extensive Fusions without CC/MCC

CC – Complication and/or Comorbidity. MCC – Major Complication and/or Comorbidity.
*Other MS-DRGs may be applicable. MS-DRG will be determined by the patient's diagnosis and any procedure(s) performed.

Table 5. HCPCS (Healthcare Common Procedure Coding System)[4]

MS-DRG	Description
C1889	Implantable/insertable device for device intensive procedure, not otherwise classified
L8699	Prosthetic implant, not otherwise specified

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