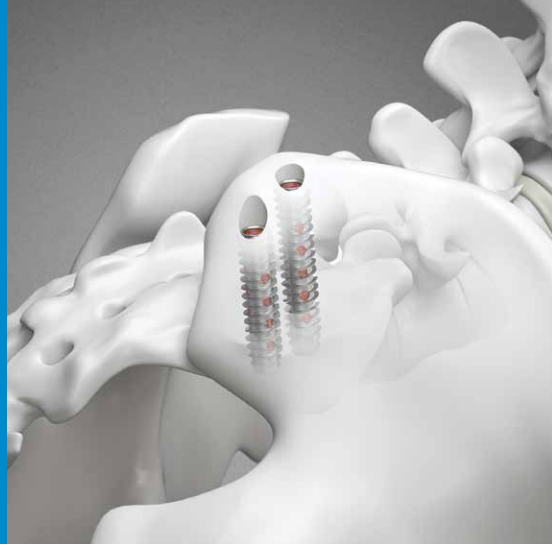
REIMBURSEMENT
GUIDE

Rialto™ SI Fusion System



Device Description

The Rialto Sacroiliac Fusion System consists of cannulated, fenestrated devices to provide stabilization when fusion of the sacroiliac joint is desired. The devices are offered in various lengths to accommodate patient anatomy. Autograft and/or allograft such as Grafton Demineralized Bone Matrix (DBM) Putty may be placed in conjunction with the Rialto SI Fusion System. One, two, or three devices may be implanted via a minimally invasive approach at the surgeon's discretion.

Indications for Use

The Rialto SI Fusion System is intended for Sacroiliac Joint fusion for conditions including Sacroiliac Joint disruptions and degenerative sacroiliitis.

ICD-10-CM Procedure Codes

All claim forms must include ICD-10-CM diagnosis codes to report the patient's condition. These codes reflect the physician's assessment of a particular patient's condition. Providers may wish to contact their Medicare contractor or third-party payers to determine coverage and ICD-10-CM diagnosis codes that support medical necessity for The Rialto SI Fusion System. The following diagnosis codes may apply to patients undergoing a sacroiliac fusion with the Rialto SI Fusion System:

Code	Description
M46.1	Sacroiliitis not elsewhere classified
M53.2X8	Spinal instabilities, sacral and sacrococcygeal region

Providers should report the ICD-10-CM diagnosis code that most accurately describes the patient's condition. Please refer to the payer's policy for ICD-10-CM diagnosis codes that support medical necessity in your region. Multiple diagnosis codes may be required.

PHYSICIAN **REIMBURSEMENT**

Physicians use Current Procedural Terminology (CPT®) codes to report all of their services. These codes are uniformly accepted by all payers. Medicare and most indemnity insurers use a fee schedule to pay physicians for their professional services, assigning a payment amount to each CPT code. Under Medicare's Resource-Based Relative Value Scale (RBRVS) methodology for physician payment, each CPT code is assigned a point value, known as the Relative Value Unit (RVU), which is then multiplied by a conversion factor to determine the physician payment. Many other payers use Medicare's RBRVS fee schedule or a variation on it. Industrial or work-related injury cases are usually reimbursed according to the official fee schedule for each state.

Use of CPT codes is governed by various coding guidelines published by the American Medical Association (AMA) and other major sources such as physician specialty societies. In addition, the National Correct Coding Initiative (NCCI), a set of CPT coding edits created and maintained by the Centers for Medicare and Medicaid Services (CMS), has become a national standard.

Medtronic

The following CPT code may be appropriate for the Rialto SI Fusion System:

CPT	Description	RVU	2016 Medicare Payment*
27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device (For bilateral procedure, report 27279 with modifier 50)	20.04	$717.52

*Source: CY2016 Medicare Physician Fee Schedule, Final Rule. Federal Register, November 16, 2015. No geographic adjustments.

FACILITY REIMBURSEMENT

Inpatient Reimbursement

Hospital payment for inpatient services/procedures is usually based on Diagnosis-Related Groups (DRGs), case rates, per diem rates or a line item payment methodology. Medicare uses the Medicare Severity-DRG (MS-DRG) payment methodology to reimburse hospitals for inpatient services. Each inpatient stay is assigned to one payment group, based on the ICD-10 codes assigned to the major diagnoses and procedures. Each DRG has a flat payment rate which bundles the reimbursement for all services the patient received during the inpatient stay. Most insurers pay the hospital on a contractual basis (i.e., case rate or per diem rate) that has been negotiated between the hospital and insurance carrier.

ICD-10-PCS Procedure Codes

Hospitals use ICD-10-PCS procedure codes to report inpatient services. The following ICD-10-PCS codes may be appropriate for a sacroiliac joint fusion procedure with the Rialto SI Fusion System:

Code	Description
0SG734Z	Fusion of right sacroiliac joint, with internal fixation device, percutaneous approach
0SG834Z	Fusion of left sacroiliac joint, with internal fixation device, percutaneous approach

Possible Medicare-Severity Diagnosis-Related Groups (MS-DRG)

Medicare Severity—Diagnosis Related Group (MS-DRG) Assignment

MS-DRG	Description	MDC	Relative Weight*	FY'17 Medicare Payment*
028	Spinal Procedures with MCC	01	5.5439	$33,057.89
029	Spinal Procedures with CC or Spinal Neurostimulator	01	3.1882	$19,011.01
030	Spinal Procedures without CC/MCC	01	1.9008	$11,334.34
459	Spinal Fusion Except Cervical with MCC	08	6.5532	$39,076.27
460	Spinal Fusion Except Cervical without MCC	08	3.9894	$23,788.51

*Source: FY2017 Medicare Hospital Inpatient Prospective Payment System, Final Rule. Federal Register, August 22, 2016.Updated with Correction Notice dated October 5, 2016. Assumes payment for a hospital with wage index and geographic adjustment factor of 1.000 and submitted quality data and is a meaningful EHR user.

CC-Complications and/or comorbidities, MCC-Major complications and/or comorbidities.

Under the MS-DRG system, cases may be assigned to a number of other MS-DRGs, based on individual patient diagnosis and presence or absence of additional surgical procedures performed. Additional MS-DRGs include but are not limited to: MS-DRGs 907, 908, 909; MS-DRGs 957, 958, 959; and MS-DRGs 981, 982, 983.

Outpatient Reimbursement

Hospitals use the Healthcare Common Procedure Coding System (HCPCS) to report outpatient services. Under Medicare's methodology for hospital outpatient payment, each HCPCS code is assigned to one Ambulatory Payment Classification (APC). Each APC has a relative weight which is multiplied by a conversion factor to determine the hospital payment. An APC and payment amount are assigned to each significant service. Although some services are bundled and not separately payable, total payment to the hospital is the sum of the APC amounts for the services provided during the outpatient encounter.

Many payers use Medicare's APC methodology or a similar type of fee schedule to reimburse hospitals for outpatient services. Other payers use a percentage of charges mechanism, depending on their contract with the hospital.

CPT	Description	APC	Status Indicator	2016 Medicare Payment*
27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device (For bilateral procedure, report 27279 with modifier 50)	5125	J1	$10,537.90
C1713	Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)	--	N	N/A

*Source: CY2016 Medicare Outpatient Prospective Payment and Ambulatory Surgery Center Payment Systems, Final Rule. Federal Register, November 13, 2015.

Medicare requires hospitals to use HCPCS C-codes in conjunction with procedures that require the implantation of a device that are assigned to a device-intensive APC under the Medicare Hospital Outpatient Prospective Payment System. Code C1713 may be appropriate to meet this Medicare requirement, although no additional payment is made for the implant(s).

Status Indicators

Each HCPCS code in the Outpatient Prospective Payment System (OPPS) is assigned a status indicator to signify whether a discount (payment reduction) applies to the respective APC payment. The following status indicator is represented in this procedure:

J1 Hospital Part B services paid through a comprehensive APC

" Paid under OPPS; all covered Part B services on the claim are packaged with the primary ""J1"" service for the claim, except services with OPPS SI=F,G, H, L and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services."

Ambulatory Surgery Centers

Ambulatory Surgery Centers (ASCs) use CPT and HCPCS codes to report their services. Medicare's payment methodology is based on the hospital outpatient APCs, but using payments unique to ASCs.

Many payers use a similar type of fee schedule to reimburse ASCs, while other payers use alternate mechanisms depending on their contracts with the ASC.

CPT	Description	APC	Status Indicator	2016 Medicare Payment*
27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device (For bilateral procedure, report 27279 with modifier 50)	5125	J8	$7,886.65

* Source: CY2016 Medicare Outpatient Prospective Payment and Ambulatory Surgery Center Payment Systems, Final Rule. Federal Register, November 13, 2015.

Payment Indicators

Each code in the ASC Payment System is assigned a payment indicator to signify certain payment rules. The following status indicator is represented in this procedure:

J8 Device-intensive procedure; paid at adjusted rate.

MEDICAL NECESSITY

Prior Authorization

General questions about spine reimbursement for surgeon or hospital

Assistance with a prior authorization or denial may be available from Medtronic for patients whose medical needs are consistent with FDA approved/cleared indications or are otherwise in accordance with payer policies.* Prior authorization requests for sacroiliac joint fusion may require the following items:

- Progress notes
- X-ray and/or MRI reports
- Medicare or other coverage policies
- Clinical literature (available from Medtronic upon request)

*Contact Medtronic's Therapy Access Solutions at (866) 446-3873 for assistance.

Site of Service

Medical necessity will dictate site of service for each individual patient. Physicians should confirm inpatient or outpatient admission criteria before selecting site of service.

Documentation

- Medical record documentation is key to communicating essential information for making a decision as to whether a procedure was reasonable and necessary for a particular patient
- At minimum, the medical record should convey information about a patient's medical condition, the rationale for why sacroiliac joint fusion was needed, and the outcome of the procedure.
- Medical record documentation should include a detailed history and physical, which enables billing personnel to verify that a claim is coded specifically and accurately. For example, some payers require documentation that conservative care has been tried and has failed.

See payer policy for specific documentation and clinical coverage criteria.

Computer-Assisted Surgical Navigation

There are established add-on CPT codes that describe computer-assisted navigational services for various anatomic regions. The appropriate CPT code for CASN with sacroiliac fusion is +0054T, computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on fluoroscopic images. Add-on codes are always performed in addition to the primary service or procedure and must never be reported as stand-alone codes. CPT does not provide these add-on codes that describe computer-assisted navigational services with a list of primary procedure codes to which they must be applied. Providers should refer to payer policies and guidelines for reporting computer-assisted navigational services with minimally invasive sacroiliac joint fusion.

CODING REIMBURSEMENT **ASSISTANCE**

SpineLine®

Provides coding, billing and reimbursement assistance for procedures performed using Medtronic products.

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NOTES

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For additional reimbursement information contact the SpineLine® Coding and Reimbursement Support Line at (877) 690-5353.

The materials and information cited here are for informational purposes only and are provided to assist in obtaining coverage and reimbursement for health care services. However, there can be no guarantee or assurances that it will not become outdated, without the notice of Medtronic, Inc., or that government or other payers may not differ with the guidance contained here. The responsibility for coding correctly lies with the healthcare provider ultimately, and we urge you to consult with your coding advisors and payers to resolve any billing questions that you may have. All products should be used according to their labeling.

Consult instructions for use at this website www.medtronic.com/manuals.

Note: Manuals can be viewed using a current version of any major internet browser. For best results, use Adobe Acrobat® Reader with the browser.

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