

# Prior Authorization Information for **coflex**® Interlaminar Stabilization® with Decompression

Current as of April 1, 2020



## QUICK REFERENCE

### INFORMATION TO DOCUMENT

#### History & Physical Information

- **Physical symptoms of pain and location** (radicular symptoms inclusive of buttock/leg pain and/or back pain). If you have determined that your patient suffers from moderate to severe spinal stenosis, consider documenting the presence of neurogenic claudication
- **Degree of pain** (persistent, disabling, duration of pain). Are narcotics required? Is pain modifiable with position or medication?
- **Degree of functional impairment:** If you have determined your patient suffers from moderate to severe functional impairment, consider documenting the impact on ADLs, presence of distance limited gait, leg weakness or numbness, inability to walk upright, and/or need for gait support.
- **Conservative treatment failure** (what treatments and length of treatments)? Conservative treatment to include patient education, modification of activities, NSAIDs, oral or injectable steroids, braces, physical therapy or other treatments. Consider documenting start and end dates along with response to the attempted conservative treatment.
- **Is there a spondylolisthesis present?** Consider documenting degree/Grade of spondylolisthesis and stability with flexion and extension films.

#### Imaging

- **(MRI, CT, X-ray)** Consider documenting the presence/degree of stenosis, number of levels, and comments about the integrity of the facet joints at the index level of planned surgery.

#### Plan

- **What the physician is planning to do:** Consider documenting steps and details of surgical plan inclusive of any anticipated physician concerns regarding post decompression iatrogenic instability and/or facet joint integrity.

### HELPFUL HINTS

- You want your submission to be detailed, concise and supported by clinical documentation
- The insurance company is likely to require only the last imaging reports, unless patient has had prior lumbar surgery
- Highlights or underlines may interfere with the prior authorization review — consider starring important information off to the side
- If able, submit your request with more than ample time to process prior to surgery to be able to contend with any possible denials

1. CPT 2020 Professional Edition, 2020 American Medical Association (AMA); CPT is a trademark of the AMA.
2. ICD-10-CM Diagnosis Coding System, 2020 Tables and Index, Medicare/Coding/ICD-10/2020-ICD-10-CM, www.cms.gov
3. ICD-10-PCS Procedure Coding System, 2020 Tables and Index, Medicare/Coding/ICD-10/2020-ICD-10-PCS, www.cms.gov
4. Medicare Severity Diagnosis Related Group (MS-DRG) Grouper and Medicare Code Editor (MCE) Version 34 ICD-10 Software, FY 2020 IPPS Final Rule, CMS-1655-F, Medicare/AcuteInpatientPPS/FY2020-PPS, www.cms.gov
5. CMS-1656-FC – Hospital Outpatient Prospective Payment – Final Rule with Comment and Final CY2020 Payment Rates – Addendum C, www.cms.gov

\* Note: this is not intended to be a complete listing of options and other ICD-10-PCS codes may reflect the actual lumbar decompression procedure as documented in the operational note.

It is the responsibility of the healthcare provider to determine the best treatment for each patient based on each patient's condition and diagnosis. The codes denoted within are suggestions only. This information should not be construed as authoritative. Codes and values are subject to frequent change without notice. The entity billing Medicare and/or third party payors is solely responsible for the accuracy of the codes assigned to the services and items in the medical record. Therefore healthcare providers must use great care and validate billing and coding requirements ascribed by payors with whom they work. When making coding decisions, we encourage you to seek input from the AMA, relevant medical societies, CMS, your local Medicare Administrative Contractor and other health plans to which you submit claims. All data referenced herein are based on publicly available information.

### Physician CPT Codes

#### CPT 22867<sup>1</sup>

Insertion of interlaminar / interspinous process stabilization / distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level

#### CPT + 22868<sup>1</sup>

Second level (list separately in addition to code for primary procedure)

### ICD-10-CM<sup>2</sup> Diagnosis Codes

#### M48.061 & M48.062

Spinal Stenosis, Lumbar Region

#### M99.23

Subluxation Stenosis of Neural Canal of Lumbar Region

#### M99.33

Osseous Stenosis of Neural Canal of Lumbar Region

#### M99.43

Connective Tissue Stenosis of Neural Canal of Lumbar Region

#### M99.53

Intervertebral Disc Stenosis of Neural Canal of Lumbar Region

#### M99.63

Osseous and Subluxation Stenosis of Intervertebral Foramina of Lumbar Region

#### M99.73

Connective Tissue and Disc Stenosis of Intervertebral Foramina of Lumbar Region

### ICD-10-PCS<sup>3</sup> Inpatient Procedure

#### Codes\*0SB00ZZ

Excision / Lumbar Vertebral Joint, Open Approach

#### 00NY0ZZ

Release Lumbar Spinal Cord, Open Approach

#### 0SH00BZ

Insertion of Interspinous Process Spinal Stabilization Device into Lumbar Vertebral Joint, Open Approach

#### MS-DRG 518<sup>4</sup>

Back and Neck Procedures Except Spinal Fusion with MCC or Disc Device / Neurostimulator

### Hospital Outpatient

#### C-APC 5116<sup>5</sup>

Level 6 Musculoskeletal Procedures

NOTE: Please Stipulate Hospital Outpatient

### Ambulatory Surgical Center (ASC) Codes

#### CPT 22867<sup>1</sup>

1 or 2 Level

(+CPT 22868<sup>1</sup>)

# Appeal Considerations for **coflex® Interlaminar Stabilization®** with Decompression

## COVERAGE ACCESS PROCESS

### Stages of the prior authorization process

#### Initiate Prior authorization (1–15 Days)

- Verify benefits and submit clinical information and literature on device

#### Peer-to-Peer (1–3 Days)

- Opportunity for the treating physician to discuss the medical necessity of the case with a Medical Director at the health plan

#### 1st Level Appeal (3–30 Days)

- Expedited/Standard: Opportunity to request a Medical Director that did not review the initial submission - there may be one or two levels of internal appeals

#### 2nd Level Appeal (3–30 Days)

- Expedited/Standard: Opportunity to request a Medical Director that did not review the initial submission as well as the peer-to-peer

#### External Appeal (5–45 Days)

- Following appeal denial at all available internal levels, the patient may pursue an External Appeal with the applicable state Department of Insurance

#### Post Claim Denial Appeal (5–60 Days)

- Following a claim denial the patient, provider or facility may pursue an appeal with the health plan

## HELPFUL INFORMATION

### Note the following:

- Prior authorization assistance is available to providers/patients with established case only
- Case must be initiated by the provider or provider's staff
- Contact the Coverage Access Support Center at the hotline number: 1-855-636-5364
- Available Monday – Friday, 8:30am – 5:00pm ET
- Commercial insurance prior authorizations or Medicare Advantage, no Medicare or government payors
- Remember to leave sufficient time for prior authorization process and appeals
- Coordinate with facility

### Why should providers consider contacting the Support Center?

- Experienced professionals are available to help patients and practices through the prior authorization process

## COVERAGE ACCESS HINTS

### Best practices for individual case coverage

- Set expectations with the patient and provider—the approval may come quickly or may require appeals
- Fully describe the clinical justification (assume that the reviewer understands nothing about the treatment options)
- Exhaust all appeals when possible - many cases are approved at external review but most patients give up before this step

### Examples of common problems encountered

- A provider seeks assistance with an off-label case or government plans
  - The Coverage Access Support Center cannot provide assistance for these cases
  - If the issue is discovered after initial intake, the Coverage Access Support Center must cease assistance
- A provider seeks assistance within the seven days prior to scheduled surgery
  - Initial prior authorization submission can take seven days or more AFTER submission
  - The initial prior authorization answer may not even be received by the surgery date
  - This is a common frustration for providers when the appeal process is unclear
- A provider expects the Coverage Access Support Center to contact the office to initiate the appeal process
  - The provider office must contact the Coverage Access Support Center
  - The Coverage Access Support Center staff cannot call offices to initiate discussion under any circumstances

## FOR COVERAGE ACCESS SUPPORT, CONTACT:

855-636-5364

[coflexreimbursement@surgalign.com](mailto:coflexreimbursement@surgalign.com)

Available Monday – Friday, 8:30am – 5:00pm ET

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