# 2024 Coding and Reimbursement Guidelines

2024

For the Aurora Spine SiLO TFX™ Transfixing SI Joint Fusion Implant System

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## Overview

As the clinical proficiencies within a particular specialty advance and technology evolves, the reimbursement landscape for these services must also change to accommodate for the reporting and coverage of these new services. This Coding and Reimbursement Guide has been developed to provide guidance for reference when determining the applicable physician and facility coding for the Aurora Spine SiLO TFX™ Transfixing MIS SI Joint Fusion System. Additionally, pre-authorization/appeals guidance and Medicare National Average reimbursement rates are also provided for reference. Please note actual reimbursement rates will vary dependent upon the negotiated provider contracts and the payor should be contacted directly to determine specific payment rates.

## Indications for Use[i]

The Aurora Spine SiLO TFX™ MIS Sacroiliac Joint Fixation System is intended for sacroiliac joint fusion for conditions including sacroiliac joint disruptions and degenerative sacroiliitis.

## Product Description

The Aurora Spine SiLO TFX MIS Sacroiliac Joint Fixation System includes the SiLO TFX Cone, SiLO TFX Screw, and associated manual surgical instruments. The SiLO TFX Cone is comprised of titanium alloy and incorporates a hollow conical shaped barrel with two openings for bone screws for additional anchoring. During the procedure, the implant is inserted in line with the SI Joint via a posterior surgical approach with bone graft material placed in the barrel of the implant to facilitate additional bone incorporation after surgery.

## Physician Coding Recommendation

AMA CPT® Codes are utilized by physicians to report the services they provide to their patients in all settings of care. Physicians are separately reimbursed from the facility services. The rate of reimbursement is provider specific and will be dependent upon the region, negotiated contracted rate and the payer, among other things.

The table below outlines the CPT®, descriptor and Medicare national average payment rate for SiLO TFX™ Transfixing SI Joint Fusion.

| CPT® CODE | DESCRIPTION | RVU | MEDICARE NATIONAL AVERAGE PROFESSIONAL FEE 2024[iii] |
|---|---|---|---|
| **27279** | Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device | 24.40 | $791.18 |

## AMA CPT® Modifiers

The following Modifiers may be used in conjunction with the CPT® codes for reporting the primary surgical procedure. Please reference the current year AMA CPT® Coding Manual for a full listing of the available Modifiers.

| MODIFIER | DESCRIPTION |
|---|---|
| -51 | Multiple Procedures |
| -59 | Distinct Procedural Service |
| -50 | Bilateral |

## Hospital Outpatient/Ambulatory Surgery Center

Minimally Invasive SI Joint fusion is payable in the ambulatory surgery centers and hospital outpatient department settings of care. In order to better understand the facility reimbursement in an ASC and hospital outpatient setting, outlined below are the applicable CPT® codes this time listed with their associated ambulatory surgery center and hospital outpatient facility Medicare National Average payment rates. Please note the ASC rate is about 65% of the hospital outpatient APC payment rate.

| CPT® CODE | DESCRIPTION | Medicare National Average Payment Hospital Outpatient 2024[vii] | Medicare National Average Payment Ambulatory Surgery Center 2024/ Payment Indicator* |
|---|---|---|---|
| 27279 | Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device | 5116 - $17,775/J8 | $14,715.82/J8 |

*Status Indicator-J1 Comprehensive APC, N No additional payment, payment included in line items with APCs for incidental service. Payment Indicator- J8 Device-intensive procedure; paid at adjusted rate.

## HCPCS Code

Medical/surgical products and medical devices used in the provision of clinical services are reported using the Healthcare Common Procedural Coding System (HCPCS) Level II coding system. HCPCS codes are 5-digit alphanumeric codes used to report non-physician services like ambulance services and supplies. In some instances, the reporting of the HCPCS code can result in additional payment to either the physician or facility. This additional payment is dependent on the code itself. Where there is no additional payment, it may still be necessary to report the HCPCS code when billing for certain services/products in order to meet CMS reporting requirements.vii

When determining whether or not there were existing HCPCS Codes that may be applicable for the SiLO TFX™ Transfixing SI Joint Fusion System. Below is the HCPCS which may be applicable for use when reporting the SiLO TFX™ Transfixing SI Joint Fusion System.

| ICD-10-PCS | DESCRIPTION |
|---|---|
| C1889 | Implantable/insertable device, not otherwise classified |

# Insurance Pre-Authorization Process

**Pre-Authorization and Medical Necessity**
Most insurance companies will require pre-authorization of surgical services prior to rendering a surgical service. SiLO TFX™ Transfixing SI joint fusion is a surgical service and as such a pre-authorization request should be submitted to the applicable insurance company for consideration and approval. Pre-authorization requests can be submitted verbally or in writing. Both types of submission should result in a case specific pre-authorization number or written approval.

When submitting the pre-authorization request it is important to include all of the applicable CPT® codes. This should include the applicable arthrodesis, instrumentation and bone graft codes. In addition, the diagnosis code should support the medical necessity for providing the service. The payor specific medical necessity criteria should be referenced in order to avoid any denials due to not having met the published criteria. This information is most often available by referencing the payor specific medical coverage policy. For assistance with locating a policy please feel free to call the Coding and Reimbursement Hotline at 800-390-3092.

**Appeals**
In the event the procedure is denied, the provider or member appeals rights may be utilized. The appeals process allows the provider and member several opportunities to appeal for coverage of the denied services. Through this process, the provider and/or member will provide the insurance company with documentation supporting their reasoning for providing the service as well as any supporting evidence. Outlined below is a summary of each step of the appeals process.

**First Level Appeal** - The first level appeal can be submitted by the provider or patient directly to the insurance company. Once received it is sent to an internal medical director or medical reviewer of any specialty at the insurance company for reconsideration of the denial. The reviewer will take into consideration all supporting documentation and clinical notes submitted with the request as well as any existing medical policies that may be in place for the procedure.

**Second Level Appeal** - The second level appeal can also be submitted by the provider or patient directly to the insurance company. The second level appeal is also sent to an internal insurance company medical director or reviewer of any specialty for reconsideration of the denial. All previously submitted documentation and clinical notes will be reviewed in addition to any newly submitted literature or notes.

**Third Level Appeal/External Review** - The third level appeal is an external review performed by a provider within the same or similar specialty contracted by an Independent Review Organization (IRO) not associated with the insurance company. The external review performed by the IRO provides an opportunity for an unbiased review of the previously submitted supporting documentation, clinical notes and any new documentation. The IRO reviewer is not bound by any previous determinations and has the authority to overturn the denial.

**Timeline** - Insurance companies can take up to thirty days or longer to review each pre-authorization or appeals request; therefore, it is important to allow for completion of the review when scheduling a potential procedure.



[i] *510K K221047*
[ii] *CPT® Copyright 2024 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association. The AMA assumes no liability for data contained or not contained herein*
[iii] *2024 MPFS, www.cms.hhs.gov*
[iv] *2024 IPPS Final Rule*
[v] *2024 OPPS Final Rule*
[vi] *2024 OPPS Final Rule*
[vii] *www.ascexpert.com Optum Insight*