## Percutaneous Discectomy

### Procedure Coding and Reporting Reference

<table>
<thead>
<tr>
<th>CPT code¹</th>
<th>Description</th>
<th>Physician²</th>
<th>Relative Value Units (RVUs)</th>
<th>Hospital outpatient³</th>
<th>Ambulatory surgery center³</th>
</tr>
</thead>
<tbody>
<tr>
<td>62287</td>
<td>Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with the use of an endoscope, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar.</td>
<td>N/A $595.27</td>
<td>N/A 16.54</td>
<td>C2614 5432</td>
<td>$4627.27</td>
</tr>
<tr>
<td>22899</td>
<td>Unlisted procedure, spine (There is no specific CPT Code for this procedure when performed in the cervical or thoracic spine, therefore unlisted code 22899 is appropriate to report this procedure.)</td>
<td>Contractor priced</td>
<td>Contractor priced</td>
<td>N/A N/A</td>
<td>N/A 5111</td>
</tr>
</tbody>
</table>

¹CPT code
²Payment in office, Payment in facility
³Non-facility, Facility, Device code⁴, APC, APC payment, ASC payment
⁴APC payment
References


2 Note that the addenda containing the most recent relative value units and conversion factor used to calculate Medicare physician payment rates are available on the CMS web site, via the link for Physician Fee Schedule Addendum B at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1676-F1.html.

Medicare national average physician payment rates listed in this document are based on the November 2017 release of the relative value file and conversion factor of $35.99.

3 The addenda containing relative weights, payment rates, wage indices, and other payment information are no longer printed in the Federal Register. Instead, the addenda are available only on the CMS web site. Addenda relating to the OPPS are available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1678-FC.html under the OPPS Addenda tab and addenda relating to the ASC payment system are on the same link under “Final Changes to the Ambulatory Surgical Center Payment System and CY 2018 Payment Rates.”


Notes

- “N/A” indicates that this concept does not apply, or that Medicare has not developed fee schedules in those settings of care.
- Percutaneous discectomy is by definition a multiple level procedure code. Therefore it is not appropriate to report units or use the -59 modifier for procedures performed on more than one level. CPT code 62287 is not bilateral eligible.
- C-codes are reported to Medicare for medical devices in the outpatient setting.
- Fluoroscopic guidance is packaged into other services provided in the hospital outpatient department and ambulatory surgery center.

The Dekompressor™ percutaneous discectomy probe is intended for use in aspiration of disc material during percutaneous discectomies in the lumbar, thoracic and cervical regions of the spine.

The information provided is general reimbursement information only; it is not legal advice, nor is it advice about how to code, complete or submit any particular claim for payment. Although we supply this information to the best of our current knowledge, it is always the provider’s responsibility to determine and submit appropriate codes, charges, modifiers and bills for services that were rendered. This information is provided as of December 2017 and all coding and reimbursement information is subject to change without notice.

Reimbursement has three components, coding, coverage and payment. All three must be aligned for providers to receive reimbursement for the services they furnish.

Payment rates are calculated and represent the national unadjusted payments rates. Payment to individual providers will vary based on a number of variables, including geographic location.

It is important to note that coverage will vary based upon individual patient medical necessity and specific payor coverage policies. Stryker cannot guarantee coverage or payment for products or procedures. Please contact your Medicare Administrative Contractor or Private Payor for billing, payment and coverage information.