To help answer common coding and reimbursement questions regarding spine related and graft placement procedures completed with the products in this guide, the following information is shared for educational and strategic planning purposes only. It is the sole responsibility of the treating health care professional to diagnose and treat the patient, and to and confirm coverage, coding, and claim submission guidance with the patient's health insurance plan to ensure claims are accurate, complete, and supported by documentation in the patient's medical record. Any determination regarding if and how to seek reimbursement should be made only by the appropriate members of the staff, in consultation with the physician, and in consideration of the procedure performed or therapy provided to a specific patient. Arthrex does not recommend or endorse the use of any particular diagnosis or procedure code(s) and makes no determination if or how reimbursement may be available. Of important note, reimbursement codes and payment, as well as health policy and legislation, are subject to continual change.

FDA Regulatory Clearance

Angel® System
Angel system kits are to be used intraoperatively at the point of care for the safe and rapid preparation of autologous platelet-poor plasma and platelet concentrate (platelet-rich plasma) from a small sample of peripheral blood or a small sample of a mixture of peripheral blood and bone marrow. The platelet-poor plasma and platelet-rich plasma are mixed with autograft and/or allograft bone prior to application to a bony defect for improving handling characteristics (BK190383).

AlloSync™ Demineralized Bone Matrix
AlloSync bone product is indicated for orthopedic application as filler for gaps or voids that are not intrinsic to the stability of the bony structure. AlloSync bone product is indicated to be packaged gently into bony gaps in the skeletal system as a bone graft extender (extremities, spine, pelvis) and as bony void filler of the extremities and pelvis. These defects may be surgically created or from the result of traumatic injury to the bone (K040419).

AlloSync Demineralized Bone Matrix with Cancellous Bone
For orthopedic use, AlloSync CB paste and putty are intended for use as an autograft extender (extremities, spine, pelvis) and as a bone void filler (extremities and pelvis) for bony voids or gaps that are not intrinsic to the stability of the bony structure. The AlloSync CB products are indicated to be packed gently into bony defects of the skeletal system. These defects may be surgically created or from the result of traumatic injury to the bone (K040419, K070751).

ArthroCell™ Viable Bone Matrix
Establishment registration and listing for human cells, tissues, and cellular and tissue-based products described in 21 CFR 1271.0.

BoneSync™ BioActive Synthetic Bone Void Filler
BoneSync strips and putty, combined with bone marrow aspirate (BMA), are intended for use as bone void filler to fill voids or gaps of the skeletal system in the extremities, spine, and pelvis not intrinsic to the stability of the bony structure. BoneSync strips and putty are also indicated for use in the treatment of surgically treated osseous defects or osseous defects created from traumatic injury to the bone. Following placement in the bony void or gap (defect), BoneSync strips (K063124) and putty (K062353) are resorbed and replaced with bone during the healing process.

Value Analysis Significance

Arthrex has one of the most comprehensive bone repair portfolios on the market, including advanced demineralized bone graft options, cancellous chips and cubes, and autograft bone harvesting systems. Arthrex partners with the top American Academy of Tissue Banks (AATB)-certified tissue banks to bring surgeons the highest quality bone repair products for their patients.

Coding Considerations

Codes provide a uniform language for describing services performed by health care providers. The actual selection of codes depends upon the primary surgical procedure, supported by details in the patient's medical record about medical necessity. It is the sole responsibility of the health care provider to correctly prepare claims submitted to insurance carriers.

Definitions

For purposes of CPT®[a] coding, the following definitions of approach and visualization apply. The primary approach and visualization define the service, whether another method is incidentally applied. Surgical services are presumed open, unless otherwise specified.

- **Percutaneous:** Image-guided procedures (e.g., Computer tomography [CT] or fluoroscopy) performed with indirect visualization of the spine without the use of any device that allows visualization through a surgical incision.
- **Endoscopic:** Spinal procedures performed with continuous direct visualization of the spine through an endoscope.
- **Open:** Spinal procedures performed with continuous direct visualization of the spine through a surgical opening.
- **Indirect Visualization:** Image-guided (e.g., CT or fluoroscopy), not light-based visualization.
- **Direct Visualization:** Light-based visualization; can be performed by eye, or with surgical loupes, microscope, or endoscope.

Source: AMA® CPT® 2025 Professional Edition, page 484-485

2025 Medicare National Average Rates and Allowables (Not Adjusted for Geography)		**Physician**[b,c] **Medicare National Average**		**Hospital Outpatient**[d]		**ASC**[e]
CPT Code HCPCS Code	Code Description	Facility Setting (HOPD and ASC)	Work RVU	APC and APC Description	Medicare National Average	Medicare National Average
Endoscopic Decompression of Neural Elements						
Posterior Extradural Laminotomy or Laminectomy for Decompression						
62380[f]	Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc; one interspace, lumbar	$0 (carrier priced)[h]	0.0	5114-Level 4 Musculoskeletal (MSK) procedures	$7,143.73	$3,510.84
63020[f]	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; one interspace, cervical	$1091.37	14.91	5114 – Level 4 MSK procedures	$7,143.73	$3,510.84

2025 Medicare National Average Rates and Allowables (Not Adjusted for Geography)		Physician[b,c] Medicare National Average		Hospital Outpatient[d]		ASC[e]
63030[f]	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; one interspace, lumbar	$907.64	12.0	5114 – Level 4 MSK procedures	$7,143.73	$3,510.84
(+)63035[g]	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (list separately in addition to code for primary procedure)	$225.78	3.86	Packaged service/item; no separate payment made		Packaged service/ item; no separate payment made
63040[f]	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/ or excision of herniated intervertebral disc, reexploration, single interspace; cervical	$1357.26	20.31	5114 – Level 4 MSK procedures	$7,143.73	Surgical procedure not on ASC allowable list
63042[f]	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, re-exploration, single interspace; lumbar	$1276.39	18.76	5114 – Level 4 MSK procedures	$7,143.73	$3,510.84
(+)63043[g]	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/ or excision of herniated intervertebral disc, re-exploration, single interspace; each additional cervical interspace (list separately in addition to code for primary procedure)	$0 (carrier priced)	0.0	Packaged service/item; no separate payment made		Packaged service/ item; no separate payment made
(+)63044[g]	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/ or excision of herniated intervertebral disc, re-exploration, single interspace; each additional lumbar interspace (list separately in addition to code for primary procedure)	$0 (carrier priced)	0.0	Packaged service/item; no separate payment made		Packaged service/ item; no separate payment made
63045	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), single vertebral segment; cervical	$1274.45	17.95	5114 – Level 4 MSK procedures	$7,143.73	$3,510.84
63046	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; thoracic	$1217.20	17.25	5114 – Level 4 MSK procedures	$7,143.73	$3,510.84
63047	Laminectomy, facetectomy and foraminotomy, (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar	$1094.93	15.37	5114 – Level 4 MSK procedures	$7,143.73	$3,510.84

2025 Medicare National Average Rates and Allowables (Not Adjusted for Geography)		Physician[b,c] Medicare National Average		Hospital Outpatient[d]		ASC[e]
(+)63048[g]	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (list separately in addition to code for primary procedure)	$204.75	3.47	Packaged service/item; no separate payment made		Packaged service/item; no separate payment made
(+)63052[g]	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (list separately in addition to code for primary procedure)	$251.33	4.25	Packaged service/item; no separate payment made		Packaged service/item; no separate payment made
(+)63053[g]	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional segment (list separately in addition to code for primary procedure)	$222.54	3.78	Packaged service/item; no separate payment made		Packaged service/item; no separate payment made
63055	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; thoracic	$1604.06	23.55	5114 – Level 4 MSK procedures	$7,143.73	$3,510.84
63056	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; lumbar (including transfacet or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disc)	$1466.27	21.86	5114 – Level 4 MSK procedures	$7,143.73	$3,510.84
(+)63057[g]	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; each additional segment, thoracic or lumbar (list separately in addition to code for primary procedure)	$313.44	5.25	Packaged service/item; no separate payment made		Packaged service/item; no separate payment made
Nerve Transection/Avulsion						
64772	Transection or avulsion or other spinal nerve, extradural	$550.21	7.84	5431 – Level 1 nerve procedures	$1,952.77	$924.93
Open Vertebral Fracture						
22325	Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; lumbar.	$1467.56	19.87	Inpatient-only procedure		Inpatient-only procedure
Unlisted Neuro Procedure						
64999	Unlisted procedure, nervous system	$0 (carrier priced)	0.0	5441	$259.12	$0.00 (carrier priced)

2025 Medicare National Average Rates and Allowables (Not Adjusted for Geography)		Physician[b,c] Medicare National Average		Hospital Outpatient[d]		ASC[e]
Spine Arthodesis						
Posterior Fusion						
22600	Arthrodesis, posterior or posterolateral technique, single interspace; cervical below C2 segment	$1292.89	17.40	Inpatient-only procedure[i]		Inpatient-pnly procedure
22610	Arthrodesis, posterior or posterolateral technique, single interspace; thoracic (with lateral transverse technique, when performed)	$1272.51	17.28	Inpatient-only procedure		Inpatient-only procedure
22612	Arthrodesis, posterior or posterolateral technique, single interspace; lumbar (with lateral transverse technique, when performed)	$1553.60	23.53	5116 – Level 6 MSK procedures	$18,390.05	$14,036.62
(+)22614[g]	Arthrodesis, posterior or posterolateral technique, single interspace; each additional interspace (list separately in addition to code for primary procedure)	$380.39	6.43	Packaged service/item; no separate payment made		Packaged service/item; no separate payment made
PLIF or TLIF						
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar	$1544.22	22.09	5116 – Level 6 MSK procedures	$18,390.05	Surgical procedure not on ASC allowable list
(+)22632[g]	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (list separately in addition to code for primary procedure)	$311.82	5.22	Packaged service/item; no separate payment made		Surgical procedure not on ASC allowable list
Anterior Fusion						
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy, and decompression of spinal cord and/or nerve root(s); cervical below C2	$1673.61	25.0	5115 – Level 5 MSK procedures	$12,866.82	$9,069.02
(+)22552[g]	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (list separately in addition to code for separate procedure)	$385.25	6.5	Packaged service/item; no separate payment made		Packaged service/item; no separate payment made
22554	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2	$1247.28	17.69	5115 – Level 5 MSK procedures	$12,866.82	$8,976.31

2025 Medicare National Average Rates and Allowables (Not Adjusted for Geography)		Physician[b,c]		Hospital Outpatient[d]		ASC[e]
		Medicare National Average				
22556	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic	$1659.70	24.7	Inpatient-only procedure		Inpatient-only procedure
22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	$1497.64	23.53	Inpatient-only procedure		Inpatient-only procedure
(+)22585[g]	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (list separately in addition to code for primary procedure)	$314.41	5.52	Packaged service/item; no separate payment made		Packaged service/item; no separate payment made
22586	Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5–S1	$2014.86	28.12	Inpatient-only procedure		Inpatient-only procedure
Combined Fusion						
22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique, including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression); single interspace and segment, lumbar	$1781.00	26.8	5116 – Level 6 MSK procedures	$18,390.05	Surgical procedure not on ASC allowable list
(+)22634[g]	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique, including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression); each additional interspace, lumbar (list separately in addition to code for primary procedure)	$470.97	7.96	Packaged service/item; no separate payment made		Surgical procedure not on ASC allowable list
Posterior Instrumentation						
(+)22840[g]	Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation)	$732.32	12.52	Packaged service/item; no separate payment made		Packaged service/item; no separate payment made
Allograft/Autograft						
(+)20930[g]	Allograft, morselized, or placement of osteopromotive material, for spine surgery only (list separately in addition to code for primary procedure)	$0	0.0	Packaged service/item; no separate payment made		Packaged service/item; no separate payment made
(+)20931[g]	Allograft, structural, for spine surgery only (list separately in addition to code for primary procedure)	$107.71	1.81	Packaged service/item; no separate payment made		Packaged service/item; no separate payment made
(+)20936[g]	Autograft for spine surgery only (includes harvesting the graft); local (eg, ribs, spinous process, or laminar fragments) obtained from same incision (list separately in addition to code for primary procedure)	$0	0.0	Packaged service/item; no separate payment made		Packaged service/item; no separate payment made

2025 Medicare National Average Rates and Allowables (Not Adjusted for Geography)		Physician[b,c] Medicare National Average		Hospital Outpatient[d]		ASC[e]
(+)20937[g]	Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision) (list separately in addition to code for primary procedure)	$162.38	2.79	Packaged service/item; no separate payment made		Packaged service/item; no separate payment made
(+)20938[g]	Autograft for spine surgery only (includes harvesting the graft); structural, bicortical, or tricortical morselized (through separate skin or fascial incision) (list separately in addition to code for primary procedure)	$177.58	3.02	Packaged service/item; no separate payment made		Packaged service/item; no separate payment made
(+)20939[g]	Bone marrow aspiration for bone grafting, spine surgery only, through separate skin or fascial incision (list separately in addition to code for primary procedure)	$67.93	1.16	Packaged service/item; no separate payment made		Packaged service/item; no separate payment made
Platelet-Rich Plasma						
0232T	Injection(s), platelet-rich plasma, any site, including image guidance, harvesting, and preparation when performed	$0 (carrier priced)	0.0	5735 – Level 5 minor procedures	$399.04	Packaged service/item; no separate payment made

[a] CPT (Current Procedural Terminology) is a registered trademark of the American Medical Association. Health care providers and their professional coders must closely review this primary citation along with the patient's medical record before selecting the appropriate code.

[b] AMA CPT 2025 and CMS PFS 2025 Final Rule

[c] CMS Conversion Factor (CF) effective January 1, 2025: $32.3465

[d] CMS 2025 OPPS Final Rule @ www.cms.gov

[e] CMS 2025 ASC Final Rule @ www.cms.gov

[f] Unless otherwise identified in the listings, bilateral procedures that are performed at the same session should be identified by adding modifier 50 to the appropriate 5-digit code.

[g] Indicates an add-on code that must be reported with a primary procedure.

[h] For Medicare Part B MAC-Specific fee schedule, see Addendum A

[i] For FY 2025 spinal DRGs, see Addendum B

HCPCS Code	Code Description	Notes
C1762	**Connective tissue, human** These tissues include a natural, cellular collagen, or extracellular matrix obtained from autologous rectus fascia, decellularized cadaveric fascia lata, or decellularized dermal tissue. They are intended to repair or support damaged or inadequate soft tissue.	For Medicare, anchors/screws/joint devices are not separately reimbursed in any setting of care (eg, hospital, ASC). These costs are absorbed by the facility via the appropriate reimbursement mechanism (eg, MS-DRG, APC, etc)
C1713	**Anchor / screw for opposing bone-to bone or soft tissue-to-bone (implantable)** Implantable pins and/or screws that are used to oppose soft tissue-to-bone, tendon-to-bone, or bone-to-bone. Screws oppose tissue via drilling as follows: soft tissue-to-bone, tendon-to-bone, or bone-to-bone fixation. Pins are inserted or drilled into bone, principally with the intent to facilitate stabilization or oppose bone-to-bone. This may include orthopedic plate with accompanying washers and nuts. This category also applies to synthetic bone substitutes that may be used to fill bony void or gaps (ie, bone substitute implanted into a bony defect created from trauma or surgery).	
C1889	**Implantable / insertable device for device-intensive procedure, not otherwise classified**	

C9359	**Porous purified collagen matrix bone void filler (Integra Mozaik osteoconductive scaffold putty, Integra OS osteoconductive scaffold putty), per 0.5 cc**	For non-Medicare (eg, commercial) patients, depending on contractual terms and general stipulations of the payer, direct invoicing by the facility may be allowed. Contact the patient's insurance company or the facility's payer contract for further information.
C9362	**Porous purified collagen matrix bone void filler (Integra Mozaik osteoconductive scaffold strip), per 0.5 cc**	
L8699	**Prosthetic implant, not otherwise specified** This code reports prosthetic implants that are not otherwise described in more specific HCPCS Level II codes.	
A4649	**Surgical supplies; miscellaneous** This code reports miscellaneous surgical supplies and should only be reported if a more specific HCPCS Level II or CPT code is not available.	
List of pass-through payment device category codes (updated September 2022): https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment		

For more information about the primary procedure, please speak with your admitting surgeon. You may also call the Arthrex Coding Helpline at 1-844-604-6359 or email at AskMarketAccess@arthrex.com.

The content provided in this guide is for informational purposes only. The Arthrex Coding Helpline does not guarantee reimbursement by third-party payers.

The information provided in this handout was obtained from many sources and is subject to change without notice as a result of changes in reimbursement laws, regulations, rules, and policies. All content on this website is informational only, general in nature, and does not cover all situations or all payers' rules and policies. This content is not intended to instruct medical providers on how to use or bill for health care procedures, including new technologies outside of Medicare national guidelines. A determination of medical necessity is a prerequisite that we assume will have been made prior to assigning codes or requesting payments. Medical providers should consult with appropriate payers, including Medicare fiscal intermediaries and carriers, for specific information on proper coding, billing, and payment levels for health care procedures. It is the sole responsibility of the medical provider to determine the appropriate coding.

This information represents no promise or guarantee concerning coverage, coding, billing, and payment levels. Arthrex specifically disclaims liability or responsibility for the results or consequences of any actions taken in reliance on information in this handout or through the Arthrex Coding Helpline. This guide does not constitute legal, coding, coverage, reimbursement, business, clinical, or other advice and no warranty regarding completeness or accuracy is implied.

Addendum A

Medicare Mac and Part B Jurisdiction(s)	State	CY 2025 Fee Schedule	Fee Schedule Link
Noridian JE, JF	CA, HI, NV, AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY	Contractor-priced	Fee Schedules - JF Part B - Noridian
Novitas JH, JL	AR, CO, LA, MS, NM, OK, TX, DC, DE, MD, NJ, PA	Contractor-priced	FeeLookup
CGS	OH, KY	Contractor-priced	Part B Fee Schedules/Reimbursement
Palmetto JM, JJ	WV, VA, NC, SC, TN, AL, GA	Contractor-priced	Medicare Physician Fee Schedule Part B
WPS - J8, J5	IN	$710.59	2025 Physician Fee Schedules (PFS)
	MI - Locality 1	$848.51	
	MI - Locality 99	$766.41	
	IA	$700.47	
	KS	$722.72	
	MO - Locality 1	$783.87	
	MO - Locality 2	$785.30	
	MO - Locality 99	$744.88	
	NE	$689.13	
First Coast Service Options	FL - Locality 3	$1180.72	Fee schedule lookup tool
	FL - Locality 4	$1302.58	
	FL - Locality 99	$1090.14	
	USVI	$1058.20	Fee schedule lookup tool
	PR	$943.11	Fee schedule lookup tool
NGS - J6, JK	CT	$1759.74	Fee Schedule Lookup - NGSMEDICARE
	IL - Locality 12	$1779.61	
	IL - Locality 15	$1795.65	
	IL - Locality 16	$1875.05	
	IL - Locality 99	$1625.05	
	ME - Locality 3	$1537.80	
	ME - Locality 9	$1491.25	
	MA - Locality 1	$1757.40	
	MA - Locality 99	$1685.44	
	MN	$1462.46	
	NH	$1654.26	
	NY - Locality 1	$1912.95	
	NY - Locality 2	$2052.09	
	NY - Locality 3	$1747.25	
	NY - Locality 4	$2051.29	
	NY - Locality 99	$1487.71	
	RI	$1666.25	
	VT	$1523.31	
	WI	$1429.11	

Addendum B

DRG	Description	FY 2025 National Average Payment Rate
402	Single level combined anterior and posterior spinal fusion except cervical	$27,839
426	Multiple level combined anterior and posterior spinal fusion except cervical w/ mcc or custom-made anatomically designed interbody fusion device	$74,543
427	Multiple level combined anterior and posterior spinal fusion except cervical w/ cc	$50,543
428	Multiple level combined anterior and posterior spinal fusion except cervical w/o cc/mcc	$39,167
447	Multiple level spinal fusion except cervical w/ mcc or custom-made anatomically designed interbody fusion device	$47,711
448	Multiple level spinal fusion except cervical w/o mcc	$29,058
450	Single level spinal fusion except cervical w/ mcc of custom-made anatomically designed interbody fusion device	$36,648
451	Single level spinal fusion except cervical w/o mcc	$21,960
518	Back and neck procedures except spinal fusion w/ mcc or disc device or neurostimulator	$23,675
519	Back and neck procedures except spinal fusion w/ cc	$13,026
520	Back and neck procedures except spinal fusion w/o cc/mcc	$9467