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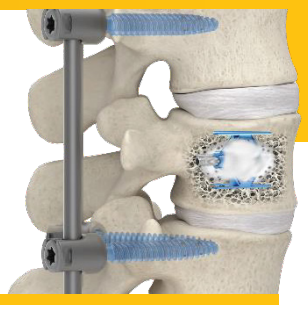
2026 reimbursement guide

Open treatment of vertebral compression fracture with posterior instrumentation and insertion of an intervertebral biomechanical device



Physician[1]

CPT® code[2]	Description	Payment in facility	Relative value units (RVUs) Facility RVUs	Global period
Open treatment/reduction				
22325	Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, one fractured vertebra or dislocated segment; lumbar	$1,444	43.24	90
22327	Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, one fractured vertebra or dislocated segment; thoracic	$1,503	45.01	90
+22328	Each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure. Use in conjunction with 2232522327)	$252	7.55	ZZZ
Instrumentation				
+22840	Posterior nonsegmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)	$668	20.01	ZZZ
+22842	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure)	$680	20.35	ZZZ
SpineJack system				
+22859	Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)	$300	8.99	ZZZ

ZZZ: Add-on codes that must be billed with another service. The Medicare PFS payment doesn't include post-operative work ZZZ codes.

ICD-10 diagnosis codes open fracture[3]

Unstable burst fracture initial encounter for open fracture of thoracic vertebra:
S22.002B unspecified thoracic vertebra
S22.012B T1 vertebra
S22.022B T2 vertebra
S22.032B T3 vertebra
S22.042B T4 vertebra
S22.052B T5T6 vertebra
S22.062B T7T8 vertebra
S22.072B T9T10 vertebra
S22.082B T11T12 vertebra

Unstable burst fracture initial encounter for open fracture of:
S32.002B unspecified lumbar vertebra
S32.012B First lumbar vertebra
S32.022B Second lumbar vertebra
S32.032B Third lumbar vertebra
S32.042B Fourth lumbar vertebra
S32.052B Fifth lumbar vertebra

ICD-10 diagnosis codes closed fracture[3]

Unstable burst fracture initial encounter for closed fracture of:
S22.002A unspecified thoracic vertebra
S22.012A T1 vertebra
S22.022A T2 vertebra
S22.032A T3 vertebra
S22.042A T4 vertebra
S22.052A T5T6 vertebra
S22.062A T7T8 vertebra
S22.072A T9T10 vertebra
S22.082A T11T12 vertebra

Unstable burst fracture initial encounter for closed fracture of:
S32.002A unspecified lumbar vertebra
S32.012A First lumbar vertebra
S32.022A Second lumbar vertebra
S32.032A Third lumbar vertebra
S32.042A Fourth lumbar vertebra
S32.052A Fifth lumbar vertebra

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Ambulatory surgery center (ASC)[4]

CPT® code[2]	Description	Payment indicator	Multiple procedure discounting	ASC payment
Open treatment / reduction				
22325	Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, one fractured vertebra or dislocated segment; lumbar	J8	Y	$9,305
22327	Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, one fractured vertebra or dislocated segment; thoracic	J8	Y	$9,499
+22328	Each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure. Use in conjunction with 2232522327)	N1	N/A	N/A
Instrumentation				
+22840	Posterior nonsegmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)	N1	N/A	N/A
+22842	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure)	N1	N/A	N/A
SpineJack system				
+22859	Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)	N1	N/A	N/A

J8: Device intensive procedure; paid at adjusted rate.
N1: Packaged service/item; no separate payment made.

ICD-10 diagnosis codes[3] open fracture

Unstable burst fracture initial encounter for open fracture of thoracic vertebra:
S22.002B unspecified thoracic vertebra
S22.012B T1 vertebra
S22.022B T2 vertebra
S22.032B T3 vertebra
S22.042B T4 vertebra
S22.052B T5T6 vertebra
S22.062B T7T8 vertebra
S22.072B T9T10 vertebra
S22.082B T11T12 vertebraUnstable burst fracture initial encounter for open fracture of:
S32.002B unspecified lumbar vertebra
S32.012B First lumbar vertebra
S32.022B Second lumbar vertebra
S32.032B Third lumbar vertebra
S32.042B Fourth lumbar vertebra
S32.052B Fifth lumbar vertebra

ICD-10 diagnosis codes[3] closed fracture

Unstable burst fracture initial encounter for closed fracture of:
S22.002A unspecified thoracic vertebra
S22.012A T1 vertebra
S22.022A T2 vertebra
S22.032A T3 vertebra
S22.042A T4 vertebra
S22.052A T5T6 vertebra
S22.062A T7T8 vertebra
S22.072A T9T10 vertebra
S22.082A T11T12 vertebraUnstable burst fracture initial encounter for closed fracture of:
S32.002A unspecified lumbar vertebra
S32.012A First lumbar vertebra
S32.022A Second lumbar vertebra
S32.032A Third lumbar vertebra
S32.042A Fourth lumbar vertebra
S32.052A Fifth lumbar vertebra

Hospital outpatient[4]

CPT® code[2]	Description	Status indicator	Ambulatory payment classification (APC)	APC payment
Open treatment / reduction				
22325	Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, one fractured vertebra or dislocated segment; lumbar	J1	5115	$13,117
22327	Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, one fractured vertebra or dislocated segment; thoracic	J1	5115	$13,117
+22328	Each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure. Use in conjunction with 2232522327)	N	N/A	N/A
Instrumentation				
+22840	Posterior nonsegmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)	N	N/A	N/A
+22842	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure)	N	N/A	N/A
SpineJack system				
+22859	Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)	N	N/A	N/A

J1: Hospital Part B services paid through a comprehensive APC.
N: Items or services packaged into APC rates.

HCPCS II device codes[5]

SpineJack system C1062
Intravertebral body fracture augmentation with implant (e.g., metal, polymer)

Cement C1713
Anchor/screw for opposing bone-to-bone (implantable)

Hospital inpatient[6]

MS-DRGs inpatient reimbursement

Code	Description	Payment
MSDRGs		
447	Multiple level spinal fusion except cervical with MCC* or custom-made anatomically designed interbody fusion device	$48,620
448	Multiple level spinal fusion except cervical without MCC*	$30,859
450	Single level spinal fusion except cervical with MCC* or custom-made anatomically designed interbody fusion device	$38,782
451	Single level spinal fusion except cervical without MCC*	$23,507
518	Back and neck procedures except spinal fusion with MCC* or disc device or neurostimulator	$27,195
519	Back and neck procedures except spinal fusion with CC**	$14,555
520	Back and neck procedures except spinal fusion without CC/MCC***	$10,871

MS-DRGs inpatient reimbursement

Hospitals use ICD 10 PCS procedure codes for inpatient services. The following ICD 10 PCS X codes are appropriate to report with the Stryker SpineJack system.

0QS004Z	Reposition lumbar vertebra with internal fixation device, open approach
0PS404Z	Reposition thoracic vertebra with internal fixation device, open approach

*Major complication or comorbidity
**Complication or comorbidity
***Complication or comorbidity/major complication or comorbidity

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Notes:
- "N/A" indicates that this concept does not apply, or that Medicare has not developed fee schedules in those settings of care.
- HCPCS C-codes are reported to Medicare for medical devices in the outpatient setting

References

1. 2026 CMS PFS Final Rule, Addendum B (published November 3, 2025). Medicare national average physician payment rates listed in this document are based on the 11/3/25 release of the relative value file and non-qualifying APM conversion factor of 33.4009. https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1832-f.
2. Current Procedural Terminology 2025, American Medical Association. Chicago, IL 2025. CPT is a registered trademark of the American Medical Association. Current Procedural Terminology (CPT®) is copyright 2025 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
3. International Classification of Diseases, Tenth Revision, Clinical Modification (ICD10CM) (available on CMS.gov). Codes shown are examples. Please check your local LCD or with the specific payer for diagnosis codes that support medical necessity.
4. 2026 CMS OPPS/ASC Final Rule, Addendum AA, B and J (published November 21, 2025). https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1834-fc.
5. Healthcare Common Procedure Coding System (HCPCS) Level II codes are maintained by the Centers for Medicare and Medicaid Services (available on CMS.gov).
6. FY 2026 IPPS Final Rule (available on CMS.gov).
7. Centers for Medicare & Medicaid Services. International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS) (available on CMS.gov).

Indications for use

For Stryker products, refer to Indications for Use section within the Instructions for Use (IFU).

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Interventional Spine

Bone cement: Serious adverse events, some with fatal outcome, associated with the use of bone cements for vertebroplasty, kyphoplasty and sacroplasty include myocardial infarction, cardiac arrest, cerebrovascular accident, pulmonary embolism and cardiac embolism. Although it is rare, some adverse events have been known to occur beyond a year or more postoperatively. Additional risks exist with the use of bone cement. Please see the IFU for a complete list of potential risks.

This document is intended solely for the use of healthcare professionals. Reimbursement, coding, coverage and payment information is provided for general information only and is not intended to provide coverage, coding, payment, medical treatment or legal advice. Stryker does not warrant, promise, guarantee or make any statement that the codes supplied in this guide are appropriate for any individual patient or that the use of this information will result in coverage or payment for treatment using any Stryker products or that any payment received will reimburse a provider's costs. The information is not intended to guarantee or increase payment by any payor. Laws, regulations and policies concerning reimbursement are complex, subject to change and updated regularly.

Stryker does not assume any responsibility for coding decisions, nor does it recommend codes for specific patients' procedures. The provider is solely responsible for reporting the codes that accurately describe the services furnished to a particular patient as well as the patient's medical condition. It is the provider's responsibility to determine and document that the services provided are medically necessary and that the site of service is appropriate. It is the healthcare provider's responsibility to report the patient diagnosis, the procedures performed and the products used, consistent with the specific payer's guidelines.

Stryker defers to specialty society guidelines, payer policies and guidelines, Medicare and the AMA regarding the submission of claims and the appropriate coding for procedures and products.

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 payment rates. Payment to individual providers will vary based on a number of variables, including geographic location.

This information in this document is accurate as of December 2, 2025, and all coding and reimbursement information is subject to change without notice. Please contact your Medicare Administrative Contractor or Private Payer for billing, payment and coverage information.

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