

Percutaneous vertebral augmentation



CPT code ¹	Description	Physician fees ²		Relative value units (RVUs) ²		Device code ⁴	Hospital outpatient ³	Ambulatory surgery center (ASC) ³		ICD-10 diagnosis codes ⁵	
		Payment in office	Payment in facility	Non facility RVUs	Facility RVUs		Ambulatory payment classification (APC)	APC payment	ASC payment		
Percutaneous vertebral augmentation											
22513	Thoracic Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), one vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic	\$5,206	\$493	160.96	15.25	SpineJack system C1062 Intravertebral body fracture augmentation with implant (e.g., metal, polymer)	5114	\$7,144	\$3,511	M80.08 Age-related osteoporosis with current pathological fracture, vertebra(e): M80.08XA- initial encounter for fracture; M80.08XS- sequela M80.88 Other osteoporosis with current pathological fracture, vertebra(e): M80.88XA- initial encounter for fracture; M80.88XS- sequela M84.58 Pathological fracture in neoplastic disease, other specified site (vertebra): M84.58XA- initial encounter for fracture; M84.58XS- sequela C41.2* Malignant neoplasm of vertebral column C79.51* Secondary malignant neoplasm of bone C79.52* Secondary malignant neoplasm of bone marrow C90.00* Multiple myeloma not having achieved remission C90.01* Multiple myeloma in remission C90.02* Multiple myeloma in relapse *Dual diagnosis is required.	
22514	Lumbar Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), one vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar	\$5,182	\$461	160.21	14.25						
22515	Each additional Each additional thoracic or lumbar vertebral body (list separately in addition to code for primary procedure 22513 + 22515) Note: 22514+22515 no longer qualifies for a complexity adjustment and is reimbursed out of APC 5114	\$2,657	\$210	82.13	6.48	Cement C1713 Anchor/screw for opposing bone-to-bone (implantable)	5115	\$12,867	N/A		
C7507	Procedural code pair representing codes listed Percutaneous vertebral augmentations, first thoracic and any additional thoracic or lumbar vertebral bodies, including cavity creations (fracture reductions and bone biopsies included when performed) using mechanical device (eg, kyphoplasty), unilateral or bilateral cannulations, inclusive of all imaging guidance (Code pair 22513 + 22515)	N/A	N/A	N/A	N/A	C1889 Implantable/insertable device, not otherwise classified device	N/A	N/A	\$6,633		
C7508	Procedural code pair representing codes listed Percutaneous vertebral augmentations, first lumbar and any additional thoracic or lumbar vertebral bodies, including cavity creations (fracture reductions and bone biopsies included when performed) using mechanical device (eg, kyphoplasty), unilateral or bilateral cannulations, inclusive of all imaging guidance (Code pair 22514 + 22515)	N/A	N/A	N/A	N/A				N/A		
Percutaneous sacral augmentation (sacroplasty)											
0200T	One or more needles Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used, one or more needles, includes imaging guidance and bone biopsy, when performed	N/A	N/A	N/A	N/A	N/A	5114	\$7,144	\$4,590		
0201T	Two or more needles Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, two or more needles, includes imaging guidance and bone biopsy, when performed	N/A	N/A	N/A	N/A	N/A			\$3,511		

MS-DRGs inpatient reimbursement⁶

Code	Description	Payment
MS-DRGs		
515	Other musculoskeletal system and connective tissue OR procedures with MCC*	\$22,069
516	Other musculoskeletal system and connective tissue OR procedures with CC**	\$14,357
517	Other musculoskeletal system and connective tissue OR procedures without CC/MCC***	\$10,653

*Major complication or comorbidity

**Complication or comorbidity

***Complication or comorbidity/Major complication or comorbidity

ICD-10-PCS procedure codes⁷

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.

XNU0356	Supplement Lumbar Vertebra with Mechanically Expandable (Paired) Synthetic Substitute, Percutaneous Approach, New Technology Group 6
XNU4356	Supplement Thoracic Vertebra with Mechanically Expandable (Paired) Synthetic Substitute, Percutaneous Approach, New Technology Group 6

References

1. Current Procedural Terminology 2024, American Medical Association. Chicago, IL 2024. CPT is a registered trademark of the American Medical Association. Current Procedural Terminology (CPT[®]) is copyright 2024 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
2. 2025 CMS PFS Final Rule, Addendum B (published November 1, 2024). Medicare national average physician payment rates listed in this document are based on the November 2024 release of the relative value file and conversion factor of 32.3465. <https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1807-f>.
3. 2025 CMS OPFS/ASC Final Rule, Addendum AA, B and J (published November 1, 2024). <https://www.cms.gov/medicare/regulations-guidance/fee-for-service-payment-regulations>.

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 post-operatively. Additional risks exist with the use of bone cement. Please see the IFU for a complete list of potential risks.

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 November 12, 2024, 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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4. Healthcare Common Procedure Coding System (HCPCS) Level II codes are maintained by the Centers for Medicare and Medicaid Services.
5. International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) (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.
6. FY 2025 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).

Notes

- "N/A" indicates that this concept does not apply, or that Medicare has not developed fee schedules in those settings of care.
- When CPT code 22515 is reported in the hospital outpatient department with the primary procedure code 22513, the complexity adjustment results in an adjusted APC assignment.

Indications for use

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

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 health care provider's responsibility to report the patient diagnosis, the procedures performed and the products used, consistent with the specific payer's guidelines.

Stryker Instruments
1941 Stryker Way
Portage, MI 49002

T 269 323 7700
F 800 999 3811
Toll free 800 253 3210

stryker.com

strykerIVS.com