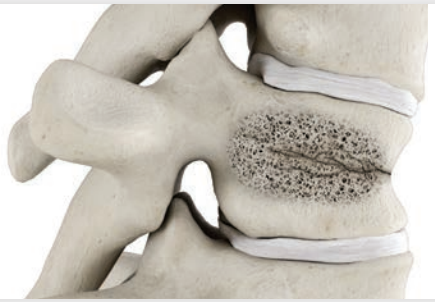
Procedure coding and Medicare payment

Percutaneous vertebral augmentation



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		Physician fees[2]		Relative value units (RVUs)[2]		Hospital outpatient[3]			Ambulatory surgery center (ASC)[3]	
CPT code[1]	Description	Payment in office	Payment in facility	Non facility RVUs	Facility RVUs	Device code[4]	Ambulatory payment classification (APC)	APC payment	ASC payment	ICD-10 diagnosis codes[5]
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	$5,510	$498	168.31	15.21	**SpineJack system C1062** Intravertebral body fracture augmentation with implant (e.g., metal, polymer) **Cement C1713** Anchor/screw for opposing bone-to-bone (implantable) **C1889** Implantable/ insertable device, not otherwise classified device	5114	$6,823	$3,393	**M80.08** Age-related osteoporosis with current pathological fracture, vertebra(e): **M80.08XA–** initial encounter for fracture; **M80.08XS–** sequelea **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	$5,486	$464	167.57	14.18					
22515	**Each additional** Each additional thoracic or lumbar vertebral body (list separately in addition to code for primary procedure 22513 + 22515 or 22514 + 22515)	$2,822	$211	86.20	6.45		5115	$12,553	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		N/A	N/A	$6,501	
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)									
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	$6,823	$4,378	
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								$3,393	

MS-DRGs inpatient reimbursement[6]

Code	Description	Payment
MS-DRGs		
515	Other musculoskeletal system and connective tissue OR procedures with MCC*	$22,136
516	Other musculoskeletal system and connective tissue OR procedures with CC**	$14,289
517	Other musculoskeletal system and connective tissue OR procedures without CC/MCC***	$10,463

*Major complication or comorbidity

**Complication or comorbidity

***Complication or comorbidity/Major complication or comorbidity

ICD-10-PCS procedure codes[7]

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 2022, American Medical Association. Chicago, IL 2022. CPT is a registered trademark of the American Medical Association. Current Procedural Terminology (CPT®) is copyright 2022 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
2. 2024 CMS PFS Final Rule, Addendum B (available on CMS website, published November 2, 2023). Medicare national average physician payment rates listed in this document are based on the November 2023 release of the relative value file and conversion factor of 32.7375.
3. 2024 CMS OPPS/ASC Final Rule, Addendum AA, B and J (available on CMS website, published November 2, 2023).
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 website). Codes shown are examples. Please check your local LCD or with the specific payer for diagnosis codes that support medical necessity.
6. FY 2024 IPPS Final Rule (available on CMS website).
7. Centers for Medicare & Medicaid Services. International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS) (available on CMS website).

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 or 22514, 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.

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 December 12, 2023, 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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