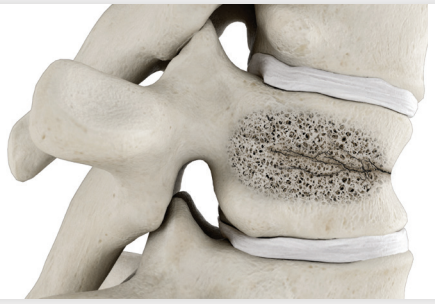
Procedure coding and Medicare payment

Percutaneous vertebroplasty



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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 codes[4]**	**Ambulatory payment classification (APC)**	**APC payment**	**ASC payment**	**ICD-10 diagnosis codes[5]**
Percutaneous vertebroplasty										
22510	**Cervicothoracic** Percutaneous vertebroplasty (bone biopsy included when performed), one vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic	$1,678	$418	51.88	12.92	**Cement C1713** Anchor/ screw for opposing bone-to-bone (implantable) **C1889** Implantable/ insertable device, not otherwise classified device	5113	$3,245	$1,579	**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.
22511	**Lumbosacral** Percutaneous vertebroplasty (bone biopsy included when performed), one vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral	$1,677	$394	51.83	12.17					
22512	**Each additional vertebral body** Each additional cervicothoracic or lumbosacral vertebral body (list separately in addition to code for primary procedure 22510 + 22512 or 22511 + 22512)	$682	$199	21.08	6.16		5114	$7,144	N/A	
C7504	**Procedural code pair representing codes listed** Percutaneous vertebroplasties (bone biopsies included when performed), first cervicothoracic and any additional cervicothoracic or lumbosacral vertebral bodies, unilateral or bilateral injection, inclusive of all imaging guidance (Code pair 22510 + 22512)	N/A	N/A	N/A	N/A		N/A	N/A	$3,511	
C7505	**Procedural code pair representing codes listed** Percutaneous vertebroplasties (bone biopsies included when performed), first lumbosacral and any additional cervicothoracic or lumbosacral vertebral bodies, unilateral or bilateral injection, inclusive of all imaging guidance (Code pair 22511 + 22512)									

MS-DRGs inpatient reimbursement[6]

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

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 OPPS/ASC Final Rule, Addendum AA, B and J (published November 1, 2024). https://www.cms.gov/medicare/regulations-guidance/fee-for-service-payment-regulations.
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).

Notes

- "N/A" indicates that this concept does not apply, or that Medicare has not developed fee schedules in those settings of care.
- For the purposes of reporting 22510, 22511, 22512, "vertebroplasty" is the process of injecting a material (cement) into the vertebral body (without creating a cavity) to reinforce the structure of the body using image guidance.
- When CPT code 22512 is reported in the hospital outpatient department with the primary procedure code 22510 or 22511, the complexity adjustment results in an adjusted APC assignment.

Indications for use

For Stryker percutaneous vertebroplasty 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 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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