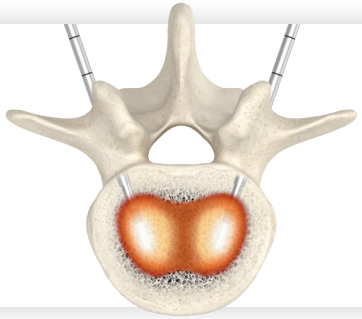
2023 reimbursement guide | vertebral body ablation

OptaBlate™ radiofrequency generator system



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		Physician fees[2]		Relative value units (RVUs)[2]			Hospital outpatient			Ambulatory surgery center (ASC)	
CPT code[1]	Description	Payment in office	Payment in facility	Non-facility RVUs	Facility RVUs	Work RVUs	Device codes[5]	Ambulatory payment classification (APC)	APC payment[3]	ASC payment[4]	ICD-10-CM diagnosis codes[6]
Ablation											
20982	Ablation therapy for reduction or eradication of 1 or more bone tumors (e.g., metastasis), including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency	$3,506	$357	106.04	10.81	7.02	**Ablation catheter C1886** Catheter, extravascular tissue ablation, any modality (insertable) **Cement C1713** Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)	5114	$6,615	$4,009	**D16.6 –** Benign neoplasm of vertebral column **D16.8 –** Benign neoplasm of pelvic bones, sacrum, and coccyx
Cementoplasty											
21899	Unlisted procedure, neck or thorax	Contractor priced	Contractor priced	N/A	N/A		N/A	N/A	N/A	N/A	N/A
27299	Unlisted procedure, pelvis or hip joint										
Biopsy of bone											
20225	Biopsy, bone, trocar, or needle, deep (e.g., vertebral body, femur)	$384	$126	11.61	3.81	2.45	N/A	5072	$1,500	$637	N/A
Vertebroplasty											
22510	**Cervicothoracic** Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic	$1,815	$424	54.90	12.82	7.90	N/A	5113	$2,977	$1,415	N/A
22511	**Lumbosacral** Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral	$1,806	$397	54.62	12.02	7.33					
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)	$729	$202	22.06	6.11	4.00	N/A	5114	$6,615	N/A	

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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	$5,745	$501	173.78	15.15	8.65	N/A	5114	$6,615	$3,138	N/A
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	$5,718	$467	172.96	14.14	7.99					
22515	**Each additional** Each additional thoracic or lumbar vertebral body (list separately in addition to code for primary procedure 22513 + 22515 or 22514 + 22515)	$2,951	$214	89.27	6.46	4.00	N/A	5115	$13,048	N/A	
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	N/A	5114	$6,615	$4,172	
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								$6,615	$3,138	

Notes

When bone tumor ablation and vertebral augmentation are performed during the same session, the two coded procedures qualify for a complexity adjustment. When 20982 and 22513 or 22514 are coded together, they map to APC 5115. When coded alone, 20982 and 22513 or 22514 map to APC 5114.

Multiple procedures

RF ablation and biopsy codes are subject to multiple procedure payment reduction when billed together during a single patient encounter. The higher-valued code will be reimbursed by Medicare at 100% of the rate, and subsequent codes will be reimbursed at 50%. Subsequent codes should be submitted with multiple procedure modifier -51.

Commercial payers typically apply a similar multiple procedure adjustment. Providers should verify payment provisions within individual commercial payer contracts.

ICD-10-PCS procedure codes[6]

Ablation: Vertebrae and spine	
0P543ZZ	Destruction of thoracic vertebra, percutaneous approach
0Q503ZZ	Destruction of lumbar vertebra, percutaneous approach
Cementoplasty: Vertebrae and spine	
0PU43JZ	Supplement of thoracic vertebra with synthetic substitute, percutaneous approach
0QU03JZ	Supplement of lumbar vertebra with synthetic substitute, percutaneous approach
Biopsy of bone: Vertebrae and spine	
0PB43ZX	Excision of thoracic vertebra, percutaneous approach, diagnostic
0Q503ZZ	Excision of lumbar vertebra, percutaneous approach, diagnostic
Vertebroplasty	
0PU43JZ	Supplement thoracic vertebra with synthetic substitute, percutaneous approach
0QU03JZ	Supplement lumbar vertebra with synthetic substitute, percutaneous approach
0QU13JZ	Supplement sacrum with synthetic substitute, percutaneous approach
Vertebral augmentation	
0PS43ZZ	Reposition thoracic vertebra, percutaneous approach
plus 0PU43JZ	Supplement thoracic vertebra with synthetic substitute, percutaneous approach
0QS03ZZ	Reposition lumbar vertebra, percutaneous approach
plus 0QU03JZ	Supplement lumbar vertebra with synthetic substitute, percutaneous approach
0QS13ZZ	Reposition sacrum, percutaneous approach sacrum, percutaneous
plus 0QU13JZ	Supplement sacrum with synthetic substitute, percutaneous approach

MS-DRGs inpatient reimbursement[7]

Code	Description	Medicare national payment
Ablation of bone neoplasm: thorax (metastases only), vertebrae and spine, shoulder and upper arm, pelvis and lower leg		
495	Local excision and removal of internal fixation devices except hip and femur W MCC*	$25,479
496	Local excision and removal of internal fixation devices except hip and femur W CC**	$14,403
497	Local excision and removal of internal fixation devices except hip and femur WO CC/MCC***	$10,438
Ablation and cementoplasty of bone neoplasm: thorax (metastases only), vertebrae and spine, shoulder (scapula), pelvis		
495	Local excision and removal of internal fixation devices except hip and femur W MCC	$25,479
496	Local excision and removal of internal fixation devices except hip and femur W CC	$14,403
497	Local excision and removal of internal fixation devices except hip and femur WO CC/MCC	$10,438
Ablation and biopsy of bone neoplasm: thorax (metastases only), vertebrae and spine, shoulder and upper arm, pelvis, upper leg and lower leg		
477	Biopsies of musculoskeletal system and connection tissue W MCC	$23,342
478	Biopsies of musculoskeletal system and connection tissue W CC	$16,112
479	Biopsies of musculoskeletal system and connection tissue WO CC/MCC	$12,130

ICD-10-CM diagnosis codes[6]

Major osseous defect (vertebroplasty, vertebral augmentation)	
M89.78	Major osseous defect, other site
Pathological fracture (vertebroplasty, vertebral augmentation)	
M84.58xA	Pathological fracture in neoplastic disease, other specified site, initial encounter

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

References

1. Current Procedural Terminology 2022, American Medical Association. Chicago, IL 2021. CPT is a registered trademark of the American Medical Association. Current Procedural Terminology(CPT®) is copyright 2021 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
2. 2023 CMS PFS Final Rule, Addendum B (available on CMS website, published November 2, 2022). Medicare national average physician payment rates listed in this document are based on the November 2022 release of the relative value file and conversion factor of 33.0607.
3. 2023 CMS OPPS/ASC Final Rule, Addendum AA, B and J (available on CMS website, published November 1, 2022).
4. Device Category Codes. Medicare Claims Processing Manual, Chapter 4 Section 60.4.2.
5. ICD-10-PCS and ICD-10-CM https://www.cms.gov/icd10m/version37-fullcode-cms/fullcode_cms/P0001.html
6. FY 2023 IPPS Final Rule Home Page (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.

IVS Reimbursement Hot Line

Questions? Contact IVS Reimbursement Hot Line | **954 302 4591** | **IVS-reimbursement@stryker.com**

Interventional Spine

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