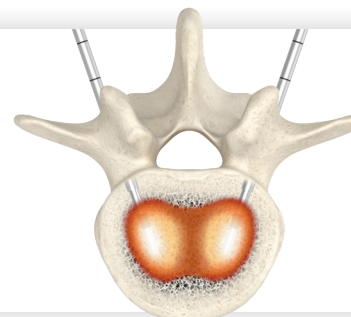


## 2023 reimbursement guide | vertebral body ablation

# OptaBlate™ radiofrequency generator system



**stryker**

CPT code <sup>1</sup>	Description	Physician fees <sup>2</sup>		Relative value units (RVUs) <sup>2</sup>			Hospital outpatient			Ambulatory surgery center (ASC)	ICD-10-CM diagnosis codes <sup>6</sup>
		Payment in office	Payment in facility	Non-facility RVUs	Facility RVUs	Work RVUs	Device codes <sup>5</sup>	Ambulatory payment classification (APC)	APC payment <sup>3</sup>	ASC payment <sup>4</sup>	
<b>Ablation</b>											
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	<b>Ablation catheter C1886</b> Catheter, extravascular tissue ablation, any modality (insertable) <b>Cement C1713</b> Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)	5114	\$6,615	\$4,009	<b>D16.6</b> – Benign neoplasm of vertebral column <b>D16.8</b> – Benign neoplasm of pelvic bones, sacrum, and coccyx
<b>Cementoplasty</b>											
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										
<b>Biopsy of bone</b>											
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
<b>Vertebroplasty</b>											
22510	<b>Cervicothoracic</b> 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	<b>Lumbosacral</b> 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	<b>Each additional vertebral body</b> 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					

CPT code <sup>1</sup>	Description	Physician fees <sup>2</sup>		Relative value units (RVUs) <sup>2</sup>			Hospital outpatient		Ambulatory surgery center (ASC)		ICD-10-CM diagnosis codes <sup>6</sup>
		Payment in office	Payment in facility	Non-facility RVUs	Facility RVUs	Work RVUs	Device codes <sup>5</sup>	Ambulatory payment classification (APC)	APC payment <sup>3</sup>	ASC payment <sup>4</sup>	
<b>Vertebral augmentation</b>											
<b>22513</b>	<b>Thoracic</b> 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
<b>22514</b>	<b>Lumbar</b> 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					
<b>22515</b>	<b>Each additional</b> 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	
<b>0200T</b>	<b>One or more needles</b> 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	
<b>0201T</b>	<b>Two or more needles</b> 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<sup>6</sup>

Ablation: Vertebrae and spine	
<b>0P543ZZ</b>	Destruction of thoracic vertebra, percutaneous approach
<b>0Q503ZZ</b>	Destruction of lumbar vertebra, percutaneous approach
Cementoplasty: Vertebrae and spine	
<b>0PU43JZ</b>	Supplement of thoracic vertebra with synthetic substitute, percutaneous approach
<b>0QU03JZ</b>	Supplement of lumbar vertebra with synthetic substitute, percutaneous approach
Biopsy of bone: Vertebrae and spine	
<b>0PB43ZX</b>	Excision of thoracic vertebra, percutaneous approach, diagnostic
<b>0Q503ZZ</b>	Excision of lumbar vertebra, percutaneous approach, diagnostic
Vertebroplasty	
<b>0PU43JZ</b>	Supplement thoracic vertebra with synthetic substitute, percutaneous approach
<b>0QU03JZ</b>	Supplement lumbar vertebra with synthetic substitute, percutaneous approach
<b>0QU13JZ</b>	Supplement sacrum with synthetic substitute, percutaneous approach
Vertebral augmentation	
<b>0PS43ZZ</b>	Reposition thoracic vertebra, percutaneous approach
<b>plus 0PU43JZ</b>	Supplement thoracic vertebra with synthetic substitute, percutaneous approach
<b>0OS03ZZ</b>	Reposition lumbar vertebra, percutaneous approach
<b>plus 0QU03JZ</b>	Supplement lumbar vertebra with synthetic substitute, percutaneous approach
<b>0OS13ZZ</b>	Reposition sacrum, percutaneous approach sacrum, percutaneous
<b>plus 0QU13JZ</b>	Supplement sacrum with synthetic substitute, percutaneous approach

## MS-DRGs inpatient reimbursement<sup>7</sup>

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

## ICD-10-CM diagnosis codes<sup>6</sup>

<b>Major osseous defect</b> (vertebroplasty, vertebral augmentation)	
<b>M89.78</b>	Major osseous defect, other site
<b>Pathological fracture</b> (vertebroplasty, vertebral augmentation)	
<b>M84.58xA</b>	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 OPFS/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](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](mailto:IVS-reimbursement@stryker.com)**

## Interventional Spine

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.

A physician must always rely on his or her own professional clinical judgment when deciding whether to use a particular product when treating a particular patient. We do not dispense medical advice and recommend that physicians be trained in the use of any particular product before using it. The information presented is intended to demonstrate Stryker’s products. A physician must always refer to the package insert, product label and/or instructions for use, including the instructions for cleaning and sterilization (if applicable), before using any of Stryker’s products. Products may not be available in all markets because product availability is subject to the regulatory and/or medical practices in individual markets. Please contact your representative if you have questions about the availability of Stryker’s products in your area.

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 5, 2022, 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.

Stryker or its affiliated entities own, use, or have applied for the following trademarks or service marks: OptaBlate and Stryker. All other trademarks are trademarks of their respective owners or holders. The absence of a product, feature, or service name, or logo from this list does not constitute a waiver of Stryker’s trademark or other intellectual property rights concerning that name or logo.

Stryker Instruments  
1941 Stryker Way  
Portage, MI 49002

t: 269 323 7700  
f: 800 999 3811  
toll free: 800 253 3210

[stryker.com](http://stryker.com)