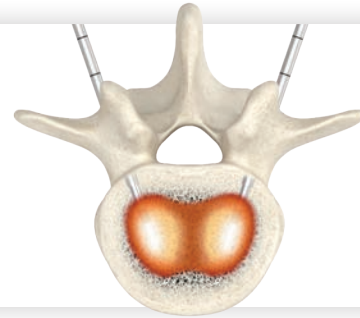


2024 reimbursement guide | vertebral body ablation



OptaBlate®
radiofrequency generator system



CPT code ¹	Description	Physician fees ²		Relative value units (RVUs) ²			Hospital outpatient			Ambulatory surgery center (ASC)	ICD-10-CM diagnosis codes ⁶
		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	
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	\$3,369	\$354	102.91	10.82	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)	5115	\$12,553	\$6,501	D16.6 – Benign neoplasm of vertebral column D16.8 – Benign neoplasm of pelvic bones, sacrum, and coccyx C79.51* – Secondary malignant neoplasm of bone M84.58XA – Pathological fracture in neoplastic disease, other specified site, initial encounter for fracture M84.58XS – Pathological fracture in neoplastic disease, other specified site, sequela
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)	\$371	\$125	11.32	3.81	2.45	N/A	5072	\$1,546	\$683	N/A

*Must be reported with either M84.58XA or M84.58XS

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
Vertebroplasty											
22510	Cervicothoracic Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic	\$1,749	\$420	53.41	12.83	7.90	Cement C1713 Anchor/screw for opposing bone-to-bone (implantable) C1889 Implantable/insertable device, not otherwise classified device	5113	\$3,087	\$1,519	M80.08XA – Age-related osteoporosis with current pathological fracture, vertebra(e), initial encounter for fracture
22511	Lumbosacral Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral	\$1,747	\$395	53.35	12.08	7.33		5114	\$6,823	N/A	M80.08XS – Age-related osteoporosis with current pathological fracture, vertebra(e), sequela
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)	\$709	\$201	21.66	6.13	4.00		5114	\$6,823	N/A	M80.88XA – Other osteoporosis with current pathological fracture, vertebra(e), initial encounter for fracture
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	8.65	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	M80.88XS – Other osteoporosis with current pathological fracture, vertebra(e), sequela C41.2* – Malignant neoplasm of vertebral column
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	7.99		5115	\$12,553	N/A	C79.51* – Secondary malignant neoplasm of bone C79.52* – Secondary malignant neoplasm of bone marrow
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	4.00		5115	\$12,553	N/A	C90.00* – Multiple myeloma not having achieved remission C90.01* – Multiple myeloma in remission
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	\$6,823	\$4,378	C90.02* – Multiple myeloma in relapse
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	N/A	5114	\$6,823	\$3,393	M84.58XA – Pathological fracture in neoplastic disease, other specified site, initial encounter for fracture M84.58XS – Pathological fracture in neoplastic disease, other specified site, sequela

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.

*Must be reported with either M84.58XA or M84.58XS

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 codes⁶

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
0OS03ZZ	Reposition lumbar vertebra, percutaneous approach
plus 0QU03JZ	Supplement lumbar vertebra with synthetic substitute, percutaneous approach
0OS13ZZ	Reposition sacrum, percutaneous approach sacrum, percutaneous
plus 0QU13JZ	Supplement sacrum with synthetic substitute, percutaneous approach

MS-DRGs inpatient reimbursement⁷

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*	\$25,074
496	Local excision and removal of internal fixation devices except hip and femur W CC**	\$13,916
497	Local excision and removal of internal fixation devices except hip and femur WO CC/MCC***	\$9,994
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	\$25,074
496	Local excision and removal of internal fixation devices except hip and femur W CC	\$13,916
497	Local excision and removal of internal fixation devices except hip and femur WO CC/MCC	\$9,994
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	\$23,588
478	Biopsies of musculoskeletal system and connection tissue W CC	\$16,690
479	Biopsies of musculoskeletal system and connection tissue WO CC/MCC	\$13,051

ICD-10-CM diagnosis codes⁶

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. 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 OPPTS/ASC Final Rule, Addendum AA, B and J (available on CMS website, published November 2, 2023).
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 2024 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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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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