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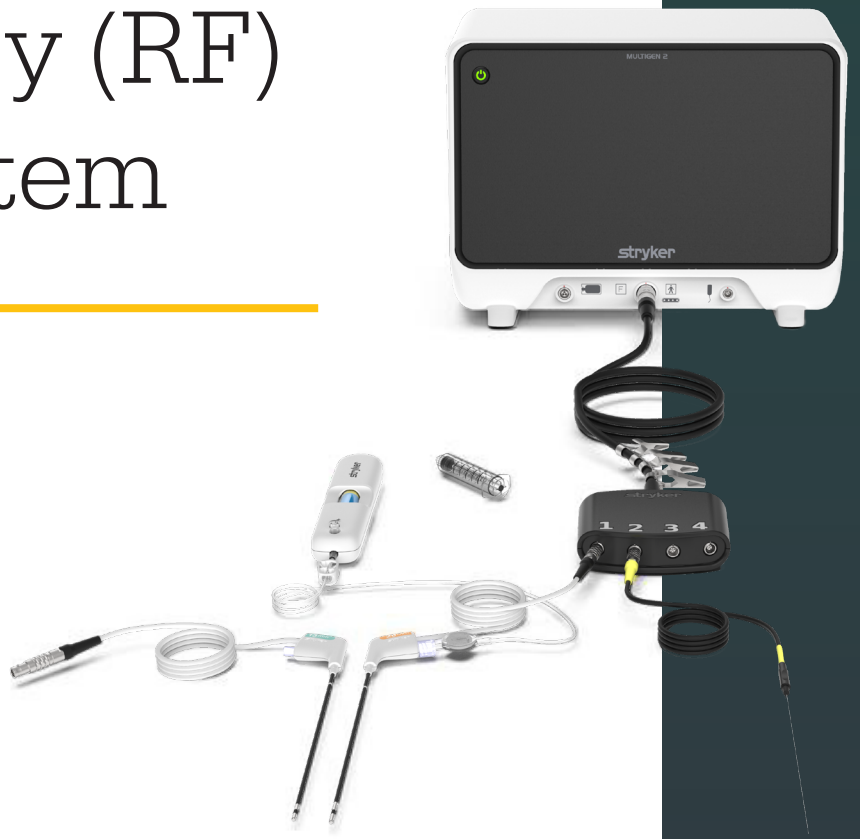
2025 reimbursement guide

OptaBlate®
radiofrequency (RF) generator system

Bone tumor ablation



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2025 reimbursement guide

OptaBlate

radiofrequency (RF) generator system

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Ablation

		Physician fees[2]		Relative value units (RVUs)[2]			Hospital outpatient			Ambulatory surgery center (ASC)	
CPT® codes[1]	Description	Payment in office	Payment in facility	Non-facility RVUs	Facility RVUs	Work RVUs	Device codes[4]	Ambulatory payment classification (APC)[3]	APC payment[3]	ASC payment[3]	ICD-10 diagnosis codes[5]
20982	Ablation therapy for reduction or eradication of one or more bone tumors (e.g., metastasis), including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency	$3,227	$353	99.76	10.92	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	$12,867	$6,633	**C79.51*–** Secondary malignant neoplasm of bone **D16.6 –** Benign neoplasm of vertebral column **D16.8 –** Benign neoplasm of pelvic bones, sacrum and coccyx **G89.3 –**Neoplasm related pain (acute) (chronic) **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

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

Ablation (continued)

ICD-10-PCS procedure codes[5]

Thorax	
0P503ZZ	Destruction of sternum, percutaneous approach
0P513ZZ	Destruction of 1 to 2 ribs, percutaneous approach
0P523ZZ	Destruction of 3 or more ribs, percutaneous approach
0P593ZZ	Destruction of right clavicle, percutaneous approach
0P5B3ZZ	Destruction of left clavicle, percutaneous approach
Vertebrae and spine	
0P543ZZ	Destruction of thoracic vertebra, percutaneous approach
0Q503ZZ	Destruction of lumbar vertebra, percutaneous approach
Shoulder and upper arm	
0P553ZZ	Destruction of right scapula, percutaneous approach
0P563ZZ	Destruction of left scapula, percutaneous approach
0P5C3ZZ	Destruction of right humeral head, percutaneous approach
0P5D3ZZ	Destruction of left humeral head, percutaneous approach
0P5F3ZZ	Destruction of right humeral shaft, percutaneous approach
0P5G3ZZ	Destruction of left humeral shaft, percutaneous approach
Pelvis, upper leg and lower leg	
0Q513ZZ	Destruction of sacrum, percutaneous approach
0Q5S3ZZ	Destruction of coccyx, percutaneous approach
0Q523ZZ	Destruction of right pelvic bone, percutaneous approach
0Q533ZZ	Destruction of left pelvic bone, percutaneous approach
0Q543ZZ	Destruction of right acetabulum, percutaneous approach
0Q553ZZ	Destruction of left acetabulum, percutaneous approach
0Q563ZZ	Destruction of right upper femur, percutaneous approach
0Q573ZZ	Destruction of left upper femur, percutaneous approach
0Q583ZZ	Destruction of right femoral shaft, percutaneous approach
0Q593ZZ	Destruction of left femoral shaft, percutaneous approach
0Q5B3ZZ	Destruction of right lower femur, percutaneous approach
0Q5C3ZZ	Destruction of left lower femur, percutaneous approach
0Q5G3ZZ	Destruction of right tibia, percutaneous approach
0Q5H3ZZ	Destruction of left tibia, percutaneous approach
0Q5J3ZZ	Destruction of right fibula, percutaneous approach
0Q5K3ZZ	Destruction of left fibula, percutaneous approach

MS-DRGs inpatient reimbursement[6]

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*	$25,125
496	Local excision and removal of internal fixation devices except hip and femur W CC**	$14,080
497	Local excision and removal of internal fixation devices except hip and femur WO CC/MCC***	$9,582
Ablation of bone neoplasm: upper leg (femur)		
498	Local excision and removal of internal fixation devices of hip and femur W CC/MCC	$18,019
499	Local excision and removal of internal fixation devices of hip and femur WO CC/MCC	$8,284
Ablation of bone neoplasm: thorax (benign only)		
166	Other respiratory system OR procedures W MCC	$27,478
167	Other respiratory system OR procedures W CC	$13,040
168	Other respiratory system OR procedures WO CC/MCC	$9,662

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

Cementoplasty

		Physician fees[2]	
CPT® codes[1]	**Description**	**Payment in office**	**Payment in facility**
21899	Unlisted procedure, neck or thorax	Contractor priced	Contractor priced
23929	Unlisted procedure, shoulder	Contractor priced	Contractor priced
24999	Unlisted procedure, humerus or elbow	Contractor priced	Contractor priced
27299	Unlisted procedure, pelvis or hip joint	Contractor priced	Contractor priced
27599	Unlisted procedure, femur or knee	Contractor priced	Contractor priced
27899	Unlisted procedure, leg or ankle	Contractor priced	Contractor priced

Cementoplasty (continued)

ICD-10-PCS procedure codes[5]

Thorax	
0PU03JZ	Supplement sternum with synthetic substitute, percutaneous approach
0PU13JZ	Supplement 1 to 2 ribs with synthetic substitute, percutaneous approach
0PU23JZ	Supplement 3 or more ribs with synthetic substitute, percutaneous approach
0PU93JZ	Supplement right clavicle with synthetic substitute, percutaneous approach
0PUB3JZ	Supplement left clavicle with synthetic substitute, percutaneous approach
Vertebrae and spine	
0PU43JZ	Supplement of thoracic vertebra with synthetic substitute, percutaneous approach
0QU03JZ	Supplement of lumbar vertebra with synthetic substitute, percutaneous approach
Shoulder and upper arm	
0PU53JZ	Supplement of right scapula with synthetic substitute, percutaneous approach
0PU63JZ	Supplement of left scapula with synthetic substitute, percutaneous approach
0PUC3JZ	Supplement of right humeral head with synthetic substitute, percutaneous approach
0PUD3JZ	Supplement of left humeral head with synthetic substitute, percutaneous approach
0PUF3JZ	Supplement of right humeral shaft with synthetic substitute, percutaneous approach
0PUG3JZ	Supplement of left humeral shaft with synthetic substitute, percutaneous approach
Pelvis, upper leg and lower leg	
0QU13JZ	Supplement of sacrum with synthetic substitute, percutaneous approach
0QUS3JZ	Supplement of coccyx with synthetic substitute, percutaneous approach
0QU23JZ	Supplement of right pelvic bone with synthetic substitute, percutaneous approach
0QU33JZ	Supplement of left pelvic bone with synthetic substitute, percutaneous approach
0QU43JZ	Supplement of right acetabulum with synthetic substitute, percutaneous approach
0QU53JZ	Supplement of left acetabulum with synthetic substitute, percutaneous approach
0QU63JZ	Supplement of right upper femur with synthetic substitute, percutaneous approach
0QU73JZ	Supplement of left upper femur with synthetic substitute, percutaneous approach
0QU83JZ	Supplement of right femoral shaft with synthetic substitute, percutaneous approach
0QU93JZ	Supplement of left femoral shaft with synthetic substitute, percutaneous approach
0QUB3JZ	Supplement of right lower femur with synthetic substitute, percutaneous approach
0QUC3JZ	Supplement of left lower femur with synthetic substitute, percutaneous approach
0QUG3JZ	Supplement of right tibia with synthetic substitute, percutaneous approach
0QUH3JZ	Supplement of left tibia with synthetic substitute, percutaneous approach
0QUJ3JZ	Supplement of right fibula with synthetic substitute, percutaneous approach
0QUK3JZ	Supplement of left fibula with synthetic substitute, percutaneous approach

MS-DRGs inpatient reimbursement[6]

Code	Description	Medicare national payment
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*	$25,125
496	Local excision and removal of internal fixation devices except hip and femur W CC**	$14,080
497	Local excision and removal of internal fixation devices except hip and femur WO CC/MCC***	$9,582
Ablation and cementoplasty of bone neoplasm: upper arm (humerus), lower leg		
492	Lower extremity and humerus procedures except hip, foot and femur W MCC	$25,343
493	Lower extremity and humerus procedures except hip, foot and femur W CC	$17,135
494	Lower extremity and humerus procedures except hip, foot and femur WO CC/MCC	$13,455
Ablation and cementoplasty of bone neoplasm: upper leg (femur)		
480	Hip and femur procedures except major joint W MCC	$20,989
481	Hip and femur procedures except major joint W CC	$14,808
482	Hip and femur procedures except major joint WO CC/MCC	$11,321
Ablation and cementoplasty of bone neoplasm: thorax (benign only)		
166	Other respiratory system OR procedures W MCC	$27,478
167	Other respiratory system OR procedures W CC	$13,040
168	Other respiratory system OR procedures WO CC/MCC	$9,662

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

Biopsy of bone

		Physician fees[2]		Relative value units (RVUs)[2]			Hospital outpatient		Ambulatory surgery center (ASC)
CPT® codes[1]	Description	Payment in office	Payment in facility	Non-facility RVUs	Facility RVUs	Work RVUs	Ambulatory payment classification (APC)[3]	APC payment[3]	ASC payment[3]
20220	Biopsy, bone, trocar, or needle, superficial (e.g., ilium, sternum, spinous process, ribs)	$220	$84	6.80	2.59	1.65	5072	$1,620	$708
20225	Biopsy, bone, trocar, or needle, deep (e.g., vertebral body, femur)	$358	$125	11.08	3.85	2.45	5072	$1,620	$708
20240	Biopsy, bone, open, superficial (e.g., sternum, spinous process, rib, patella, olecranon process, calcaneus, tarsal, metatarsal, carpal, metacarpal, phalanx)	N/A	$136	N/A	4.20	2.61	5073	$2,862	$1,202
20245	Biopsy, bone, open; deep (e.g., humeral shaft, ischium, femoral shaft)	N/A	$333	N/A	10.28	6.00	5073	$2,862	$1,202

Biopsy of bone (continued)

ICD-10-PCS procedure codes[5]

Thorax	
0PB03ZX	Excision of sternum, percutaneous approach, diagnostic
0PB13ZX	Excision of 1 to 2 ribs, percutaneous approach, diagnostic
0PB23ZX	Excision of 3 or more ribs, percutaneous approach, diagnostic
0PB93ZX	Excision of right clavicle, percutaneous approach, diagnostic
0PBB3ZX	Excision of left clavicle, percutaneous approach, diagnostic
Vertebrae and spine	
0PB43ZX	Excision of thoracic vertebra, percutaneous approach, diagnostic
0PB03ZX	Excision of lumbar vertebra, percutaneous approach, diagnostic
Shoulder and upper arm	
0PB53ZX	Excision of right scapula, percutaneous approach, diagnostic
0PB63ZX	Excision of left scapula, percutaneous approach, diagnostic
0PBC3ZX	Excision of right humeral head, percutaneous approach, diagnostic
0PBD3ZX	Excision of left humeral head, percutaneous approach, diagnostic
0PBF3ZX	Excision of right humeral shaft, percutaneous approach, diagnostic
0PBG3ZX	Excision of left humeral shaft, percutaneous approach, diagnostic
Pelvis, upper leg and lower leg	
0QB13ZX	Excision of sacrum, percutaneous approach, diagnostic
0QBS3ZX	Excision of coccyx, percutaneous approach, diagnostic
0QB23ZX	Excision of right pelvic bone, percutaneous approach, diagnostic
0QB33ZX	Excision of left pelvic bone, percutaneous approach, diagnostic
0QB43ZX	Excision of right acetabulum, percutaneous approach, diagnostic
0QB53ZX	Excision of left acetabulum, percutaneous approach, diagnostic
0QB63ZX	Excision of right upper femur, percutaneous approach, diagnostic
0QB73ZX	Excision of left upper femur, percutaneous approach, diagnostic
0QB83ZX	Excision of right femoral shaft, percutaneous approach, diagnostic
0QB93ZX	Excision of left femoral shaft, percutaneous approach, diagnostic
0QBB3ZX	Excision of right lower femur, percutaneous approach, diagnostic
0QBC3ZX	Excision of left lower femur, percutaneous approach, diagnostic
0QBG3ZX	Excision of right tibia, percutaneous approach, diagnostic
0QBH3ZX	Excision of left tibia, percutaneous approach, diagnostic
0QBJ3ZX	Excision of right fibula, percutaneous approach, diagnostic
0QBK3ZX	Excision of left fibula, percutaneous approach, diagnostic

MS-DRGs inpatient reimbursement[6]

Code	Description	Medicare national payment
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*	$24,543
478	Biopsies of musculoskeletal system and connection tissue W CC**	$16,690
479	Biopsies of musculoskeletal system and connection tissue WO CC/MCC***	$12,673
Ablation and biopsy of bone neoplasm: thorax (benign only)		
166	Other respiratory system OR procedures W MCC	$27,478
167	Other respiratory system OR procedures W CC	$13,040
168	Other respiratory system OR procedures WO CC/MCC	$9,662

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

Vertebroplasty

CPT® codes[1]	Description	Physician fees[2] Payment in office	Physician fees[2] Payment in facility	Relative value units (RVUs)[2] Non-facility RVUs	Relative value units (RVUs)[2] Facility RVUs	Relative value units (RVUs)[2] Work RVUs	Hospital outpatient Ambulatory payment classification (APC)[3]	Hospital outpatient APC payment[3]	Ambulatory surgery center (ASC) ASC payment[3]
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	7.90	5113	$3,245	$1,579
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	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)	$682	$199	21.08	6.16	4.00	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	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)								

ICD-10-PCS procedure codes[5]

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

ICD-10-CM diagnosis codes[5]

M89.78	Major osseous defect, other site
M84.58xA	Pathological fracture in neoplastic disease, other specified site, initial encounter
M80.08XA	Age-related osteoporosis with current pathological fracture, vertebra(e), initial encounter for fracture
M80.08XS	Age-related osteoporosis with current pathological fracture, vertebra(e), sequela
M80.88XA	Other osteoporosis with current pathological fracture, vertebra(e), initial encounter for fracture
M80.88XS	Other osteoporosis with current pathological fracture, vertebra(e), 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
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

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

Vertebral augmentation

CPT® codes[1]	Description	Physician fees[2]		Relative value units (RVUs)[2]			Hospital outpatient		Ambulatory surgery center (ASC)
		Payment in office	Payment in facility	Non-facility RVUs	Facility RVUs	Work RVUs	Ambulatory payment classification (APC)[3]	APC payment[3]	ASC payment[3]
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	$5,206	$493	160.96	15.25	8.65	5114	$7,144	$3,511
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	$5,182	$461	160.21	14.25	7.99			
22515	**Each additional** Each additional thoracic or lumbar vertebral body (list separately in addition to code for primary procedure 22513 + 22515) Note: 22514+22515 no longer qualifies for a complexity adjustment and is reimbursed out of APC 5114	$2,657	$210	82.13	6.48	4.00	5115	$12,867	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	5114	$7,144	$4,590
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								$3,511
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	N/A	$6,633
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)								N/A

ICD-10-PCS procedure codes[5]

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

ICD-10-CM diagnosis codes[5]

M89.78	Major osseous defect, other site
M84.58xA	Pathological fracture in neoplastic disease, other specified site, initial encounter
M80.08XA	Age-related osteoporosis with current pathological fracture, vertebra(e), initial encounter for fracture
M80.08XS	Age-related osteoporosis with current pathological fracture, vertebra(e), sequela
M80.88XA	Other osteoporosis with current pathological fracture, vertebra(e), initial encounter for fracture
M80.88XS	Other osteoporosis with current pathological fracture, vertebra(e), 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
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

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

Vertebral bone tumor ablation and multiple procedure reimbursement

		Physician fees[2]			Hospital outpatient		Ambulatory surgery center (ASC)
CPT® codes[1]	Description	Payment in office	Payment in facility	Physician work RVUs	Ambulatory payment classification (APC)[3]	APC payment[3]	ASC payment[3]
Bone tumor ablation and vertebroplasty							
20982	Ablation therapy for reduction or eradication of one or more bone tumors (e.g., metastasis), including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency	$4,066	$595	11.41	5115	$12,867	$7,423
(+) 22510	Percutaneous vertebroplasty (bone biopsy included when performed), one vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic						
20982	Ablation therapy for reduction or eradication of one or more bone tumors (e.g., metastasis), including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency	$4,066	$571	10.84	5115	$12,867	$7,423
(+) 22511	Percutaneous vertebroplasty (bone biopsy included when performed), one vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral						
(+) C7504	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	N/A	N/A	N/A	N/A	N/A	$8,389
Bone tumor ablation and vertebral augmentation							
20982	Ablation therapy for reduction or eradication of one or more bone tumors (e.g., metastasis), including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency	$6,820	$670	12.16	5115	$12,867	$8,389
(+) 22513	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., vertebral augmentation), one vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic						
20982	Ablation therapy for reduction or eradication of one or more bone tumors (e.g., metastasis), including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency	$6,796	$638	11.50	5115	$12,867	$8,389
(+) 22514	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., vertebral augmentation), one vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar						
(+) C7507	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 (e.g., kyphoplasty), unilateral or bilateral cannulations, inclusive of all imaging guidance	N/A	N/A	N/A	N/A	N/A	$9,950

Multiple procedures
Physician fees are subject to multiple procedure reduction when the above CPT code combinations are billed together. 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.

Vertebral bone tumor ablation and multiple procedure reimbursement (continued)

CPT® codes[1]	Description	Physician fees[2]			Hospital outpatient		Ambulatory surgery center (ASC)
		Payment in office	Payment in facility	Physician work RVUs	Ambulatory payment classification (APC)[3]	APC payment[3]	ASC payment[3]
Bone tumor ablation and vertebral augmentation (continued)							
20982	Ablation therapy for reduction or eradication of one or more bone tumors (e.g., metastasis), including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency	N/A	N/A	N/A	5115	$12,867	$8,928
(+) 0200T	Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used, 1 or more needles, includes imaging guidance and bone biopsy, when performed						
20982	Ablation therapy for reduction or eradication of one or more bone tumors (e.g., metastasis), including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency	N/A	N/A	N/A	5115	$12,867	$8,389
(+) 0201T	Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, 2 or more needles, includes imaging guidance and bone biopsy, when performed						
Bone tumor ablation and biopsy of bone							
20982	Ablation therapy for reduction or eradication of one or more bone tumors (e.g., metastasis), including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency"	$3,406	$415	8.25	5115	$12,867	$6,987
(+) 20225	Biopsy, bone, trocar, or needle; deep (eg, vertebral body, femur)						

Multiple procedures
Physician fees are subject to multiple procedure reduction when the above CPT code combinations are billed together. 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.

References and notes

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. 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 2025 IPPS Final Rule Home Page (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.
- When CPT code 22515 is reported in the hospital outpatient department with the primary procedure code 22513, 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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