## **stryker**

2025 reimbursement guide

OptaBlate® radiofrequency (RF) generator system

**Bone tumor ablation** 



## **stryker**

### 2025 reimbursement guide

# OptaBlate radiofrequency (RF) generator system

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#### **IVS Reimbursement Hot Line**

### Ablation

		Physicia	Relative value 'hysician fees² units (RVUs)² Hospital outpatient		Ambulatory surgery center (ASC)						
CPT <sup>®</sup> codes <sup>1</sup>	Description	Payment in office	Payment in facility	Non- facility RVUs	Facility RVUs	Work RVUs	Device codes <sup>4</sup>	Ambulatory payment classification (APC) <sup>3</sup>	APC payment <sup>3</sup>	ASC payment <sup>3</sup>	ICD-10 diagnosis codes <sup>s</sup>
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

<sup>\*</sup>Must be reported with either M84.58XA or M84.58XS

### Ablation (continued)

### ICD-10-PCS procedure codes<sup>5</sup>

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 a	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, upp	oer 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<sup>6</sup>

Code	Description	Medicare national payment
Ablat	ion of bone neoplasm: thorax (metastases only), vertebrae and spine, shoulder and upper arm, pelvis an	d 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
Ablat	ion 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
Ablat	ion 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

<sup>\*</sup> Major complication or comorbidity

<sup>\*\*</sup> Complication or comorbidity

<sup>\*\*\*</sup> Complication or comorbidity/major complication or comorbidity

## Cementoplasty

#### Physician fees<sup>2</sup>

CPT® codes¹	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<sup>5</sup>

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, up	per 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	$\label{thm:continuous} \textbf{Supplement of left upper femur with synthetic substitute, percutaneous approach}$
0QU83JZ	$Supplement \ of \ right \ femoral \ shaft \ with \ synthetic \ substitute, per cutaneous \ approach$
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	$\label{thm:continuous} \textbf{Supplement of right fibula with synthetic substitute, percutaneous approach}$
0QUK3JZ	$Supplement\ of\ left\ fibula\ with\ synthetic\ substitute,\ percutaneous\ approach$

MS-DRGs	inpatient	reimbursement <sup>o</sup>	

Code	Description	Medicare national payment
	tion and cementoplasty of bone neoplasm: thorax (metastases only), brae 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
Abla	tion 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
Abla	tion 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
Abla	tion 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

<sup>\*</sup> Major complication or comorbidity

<sup>\*\*</sup> Complication or comorbidity

<sup>\*\*\*</sup> Complication or comorbidity/major complication or comorbidity

## Biopsy of bone

		Relative value Physician fees² units (RVUs)² I		Hospital ou	ıtpatient	Ambulatory surgery center (ASC)			
CPT®	Description	Payment in office	Payment in facility	Non- facility RVUs	Facility RVUs	Work RVUs	Ambulatory payment classification (APC) <sup>3</sup>	APC payment <sup>3</sup>	ASC payment <sup>3</sup>
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<sup>5</sup>

ml	
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 a	nd 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, upp	oer 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**<sup>6</sup>

Code	Description	Medicare national payment
	tion and biopsy of bone neoplasm: thorax (metastases only), vertebrae and spine, shoulder apper 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
Abla	tion 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

<sup>\*</sup> Major complication or comorbidity

<sup>\*\*</sup> Complication or comorbidity

<sup>\*\*\*</sup> Complication or comorbidity/major complication or comorbidity

## Vertebroplasty

		Physici	an fees²	Relative value units (RVUs)²			Hospital outpatient		Ambulatory surgery center (ASC)
CPT <sup>®</sup> codes <sup>1</sup>	Description	Payment in office	Payment in facility	Non- facility RVUs	Facility RVUs	Work RVUs	Ambulatory payment classification (APC) <sup>3</sup>	APC payment <sup>3</sup>	ASC payment <sup>3</sup>
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	5110	40.045	41.550
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	5113	\$3,245	\$1,579
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)	27/4	27/4	27/4	27/2			240	40.511
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)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	\$3,511

#### ICD-10-PCS procedure codes<sup>5</sup>

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<sup>5</sup>

M89.78	Major osseous defect, other site	C79.51*	Secondary malignant neoplasm of bone
M84.58xA	Pathological fracture in neoplastic disease, other specified site, initial encounter	C79.52*	Secondary malignant neoplasm of bone marrow
M80.08XA	Age-related osteoporosis with current pathological fracture, vertebra(e), initial encounter for fracture	C90.00*	Multiple myeloma not having achieved remission
M80.08XS	Age-related osteoporosis with current pathological fracture, vertebra(e), sequela	C90.01*	Multiple myeloma in remission
M80.88XA	Other osteoporosis with current pathological fracture, vertebra(e), initial encounter for fracture	C90.02*	Multiple myeloma in relapse
M80.88XS	Other osteoporosis with current pathological fracture, vertebra(e), sequela	M84.58XA	Pathological fracture in neoplastic disease, other specified site, initial encounter for fracture
C41.2*	Malignant neoplasm of vertebral column	M84.58XS	Pathological fracture in neoplastic disease, other specified site, sequela

<sup>\*</sup>Must be reported with either M84.58XA or M84.58XS

## Vertebral augmentation

		Physician fees²		Relative value units (RVUs) <sup>2</sup>			Hospital outpatient		Ambulatory surgery center (ASC)
CPT® codes¹	Description	Payment in office		Non- facility RVUs	Facility RVUs	Work RVUs	Ambulatory payment classification (APC) <sup>3</sup>	APC payment <sup>3</sup>	ASC payment <sup>3</sup>
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								\$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	N/A N	N/A	N/A	N/A	N/A	5114	\$7,144	\$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)	DT/A	77/4	N/A	N/A	DT/A	N/A N/A	DI/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	N/A	IV/A	IV/A	N/A		N/A	N/A

#### ICD-10-PCS procedure codes<sup>5</sup>

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<sup>5</sup>

M89.78	Major osseous defect, other site	C79.51*	Secondary malignant neoplasm of bone				
M84.58xA	Pathological fracture in neoplastic disease, other specified site, initial encounter $$	C79.52*	Secondary malignant neoplasm of bone marrow				
M80.08XA	Age-related osteoporosis with current pathological fracture, vertebra(e), initial encounter for fracture	C90.00* Multiple myeloma not having achieved remission					
M80.08XS	Age-related osteoporosis with current pathological fracture, vertebra(e), sequela $$	C90.01*	Multiple myeloma in remission				
M80.88XA	Other osteoporosis with current pathological fracture, vertebra(e), initial encounter for fracture	C90.02*	Multiple myeloma in relapse				
M80.88XS	Other osteoporosis with current pathological fracture, vertebra(e), sequela	M84.58XA	Pathological fracture in neoplastic disease, other specified site, initial encounter for fracture				
C41.2*	Malignant neoplasm of vertebral column	M84.58XS	Pathological fracture in neoplastic disease, other specified site, sequela $$				

<sup>\*</sup>Must be reported with either M84.58XA or M84.58XS

### Vertebral bone tumor ablation and multiple procedure reimbursement

		Physician fees²			Hospital outpatient		Ambulatory surgery center (ASC)	
CPT® codes¹	Description	Payment in office	Payment in facility	Physician work RVUs	Ambulatory payment classification (APC) <sup>3</sup>	APC payment <sup>3</sup>	ASC payment <sup>3</sup>	
Bone tumo	or 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 tumo	or 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	40.000	\$670	12.16	5115	\$12,867	40.000	
(+) 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	\$6,820					\$8,389	
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	фсэ.o	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		\$638	11.50				
(+) 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)

			Physician fees <sup>2</sup>			Hospital outpatient	
CPT® codes¹	Description	Payment in office	Payment in facility	Physician work RVUs	Ambulatory payment classification (APC) <sup>3</sup>	APC payment <sup>3</sup>	ASC payment <sup>3</sup>
Bone tumo	or 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						\$0,920
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	<b>#0.200</b>
(+) 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						\$8,389
Bone tumo	or 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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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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