Medtronic

Balloon kyphoplasty

2024 Coding and payment guide

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For questions please contact Medtronic at neuro.us.reimbursement@medtronic.com

Physician coding and payment

January 1, 2024 – December 31, 2024

CPT Code	Description[a]	Medicare Work RVUs[b]	Medicare national average for physician services provided in:[c]	
			Office	Facility
22513[d]	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic	8.65	$5,510	$498
22514[d]	- lumbar	7.99	$5,486	$464
+22515	- each additional thoracic or lumbar vertebral body[1]	4.00	$2,822	$211

Note: In CPT, the kyphoplasty codes involve a separate and distinct mechanical device, eg, an inflatable balloon or tamp, used in an intentional manner to further develop the defect into a purposeful cavity prior to cement injection.[2]

Multiple Procedures:
The kyphoplasty codes are subject to multiple procedure reduction when billed together with other procedure codes during the same encounter. Medicare pays 100% of the rate for the higher-valued code. Medicare then pays the lower-valued code, which should be submitted with multiple procedure modifier -51, at 50% of the rate. As an exception, add-on code +22515 is not subject to discounting and is always paid at 100% of the rate.

HCPCS II device codes

Device C-codes

Device	HCPCS II device codes[e]	HCPCS II code description
Cement	C1713	Anchor/screw for apposing bone-to-bone or soft tissue-to-bone (implantable)[3]

The device C-codes above are applicable to this therapy. To determine if there is a C-code for a particular Medtronic device, click here for a C-code finder to search by model number, product name, C-code, C-code description, or product category.

Hospital outpatient coding and payment

Effective January 1, 2024 – December 31, 2024

CPT code	Description	APC[f]	APC Level	Status Indicator[f,4]	Relative weight[f]	Medicare national average[f,g]
22513	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic	5114	Level 4	J1	78.0873	$6,823
22514	- lumbar	5114	Level 4	J1	78.0873	$6,823
+22515	- each additional thoracic or lumbar vertebral body[1]	-	-	N	-	-
22513 **plus** **+22515**	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic - each additional thoracic or lumbar vertebral body[1]	5115	Level 5	J1	143.6551	$12,553
22514 **plus** **+22515**	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar - each additional thoracic or lumbar vertebral body[1]	5115	Level 5	J1	143.6551	$12,553

Note: In CPT, the kyphoplasty codes involve a separate and distinct mechanical device, eg, an inflatable balloon or tamp, used in an intentional manner to further develop the defect into a purposeful cavity prior to cement injection.[2]

ASC coding and payment

January 1, 2024 – December 31, 2024

CPT code	Description[a]	Payment indicator[h,l,5]	Multiple procedure discounting[h]	Relative weight[h,i]	Medicare national average[h,l]
22513	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic	G2	Y	63.4042	$3,393
22514	- lumbar	G2	Y	63.4042	$3,393
+22515	- each additional thoracic or lumbar vertebral body[1]	N1	N/A	N/A	N/A
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 (eg, kyphoplasty), unilateral or bilateral cannulations, inclusive of all imaging guidance	G2	Y	121.4751	$6,501
C7508	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	G2	Y	121.4751	$6,501

Note: In CPT, the kyphoplasty codes involve a separate and distinct mechanical device, eg, an inflatable balloon or tamp, used in an intentional manner to further develop the defect into a purposeful cavity prior to cement injection.[2]

Billing multiple Kyphoplasty levels:

Medicare:
ASC complexity C-codes C7507-C7508 should be assigned to report multi-level Kyphoplasty. CPT codes 22513-22515 for multi-level Kyphoplasty should not be reported to Medicare.

Commercial Payers:
ASCs should check with the specific commercial payer to determine whether C7507-C7508 are to be reported for multi-level Kyphoplasty procedures or whether CPT codes 22513-22515 should be reported.

Hospital inpatient coding and payment

Effective October 1, 2023 – September 30, 2024

Kyphoplasty

ICD-10-PCS requires purposeful creation of a cavity and also recognizes cavity creation as an attempt to at least partially restore vertebral height by intentionally repositioning bone. For this reason, kyphoplasty requires two codes in ICD-10-PCS and the codes must be used together to capture the entire procedure. The root operation for the first code is S-Reposition which represents restoration of height and spinal alignment. The root operation for the second code is U-Supplement which represents the cement injection with device value J-Synthetic Substitute used for the cement. In effect, kyphoplasty is coded as vertebral height restoration with cement injection.[6,7]

ICD-10-PCS[j] procedure codes	ICD-10-PCS procedure code description
0PS43ZZ **plus** **0PU43JZ**	Reposition thoracic vertebra, percutaneous approach Supplement thoracic vertebra with synthetic substitute, percutaneous approach
0QS03ZZ **plus** **0QU03JZ**	Reposition lumbar vertebra, percutaneous approach Supplement lumbar vertebra with synthetic substitute, percutaneous approach

Biopsy of vertebra

Vertebral biopsy is sometimes performed together with kyphoplasty and is coded separately in ICD-10-PCS.[2] Root operation B-Excision with qualifier X-Diagnostic are used for biopsy.

ICD-10-PCS procedure codes	ICD-10-PCS procedure code description
0PB43ZX	Excision of thoracic vertebra, percutaneous approach, diagnostic
0QB03ZX	Excision of lumbar vertebra, percutaneous approach, diagnostic
0QB13ZX	Excision of sacrum, percutaneous approach, diagnostic

MS-DRG assignments

Note: The MS-DRGs shown are those typically assigned with diagnosis codes commonly found on Medicare LCDs and LCAs. Other DRGs may be assigned dependent on a hospital admission specific diagnoses listed and any additional procedures performed.

Kyphoplasty for pathological fractures due to osteoporosis or malignancy

When patients are admitted for pathological fracture due to osteoporosis or malignancy and kyphoplasty procedures are performed, without any additional procedures during the same inpatient admission, the following DRGs are typically assigned.

MS-DRG[k]	MS-DRG title[8]	Relative weight[k]	Medicare national Average[l]
515	Other musculoskeletal system and connective tissue O.R. procedures W MCC	3.1615	$22,136
516	Other musculoskeletal system and connective tissue O.R. procedures W CC	2.0408	$14,289
517	Other musculoskeletal system and connective tissue O.R. procedures WO CC/MCC	1.4944	$10,463

Kyphoplasty with Vertebral Biopsy for Pathological Fractures due to Osteoporosis or Malignancy

When patients are admitted for pathological fracture due to osteoporosis or malignancy and a vertebral biopsy is performed with the kyphoplasty, the biopsy procedure code takes precedence and the following DRGs are typically assigned.

MS-DRG[k]	MS-DRG title[8]	Relative weight[k]	Medicare national Average[l]
477	Biopsies of musculoskeletal system and connective tissue W MCC	3.3690	$23,588
478	Biopsies of musculoskeletal system and connective tissue W CC	2.3837	$16,690
479	Biopsies of musculoskeletal system and connective tissue WO CC/MCC	1.8640	$13,051

Annual references

a. CPT codes, descriptions and other data only are copyright 2023 American Medical Association. All Rights Reserved. Applicable FARS/HHSARS apply. Fee schedules, relative value units, conversion factors and/or related components aren't assigned by the AMA, aren't part of CPT, and the AMA isn't recommending their use. The AMA doesn't directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

b. Centers for Medicare & Medicaid Services. CY 2024 MPFS Final Rule Home Page. Although the total RVU consists of three components, only the physician work RVU is shown.

c. Medicare national average payment is determined by multiplying the total RVU for a CPT code by the conversion factor, which is $32.7375 for CY 2024. CY 2024 MPFS Final Rule Home Page.

d. Surgical procedures are subject to a "global period." The global period defines other physician services that are generally considered part of the surgery and are not separately coded, billed, or paid when rendered by the physician who performed the surgery. The services include preoperative visits the day before or the day of the surgery; postoperative visits related to recovery from the surgery for 10 or 90 days, depending on the specific procedure; treatment of complications, unless they require a return visit to the operating room; and minor postoperative services such as dressing changes and suture removal. Medicare claims processing manual, chapter 12.

e. HCPCS quarterly update These codes are used by the entity that purchased and supplied the medical device. For Medicare hospital outpatient claims, C codes are required. For Medicare ASC claims, C codes are not reported unless the device is eligible for transitional pass-through payment. For non-Medicare hospital or ASC claims, please consult payer specific contracts for whether the C code would be billed.

f. Centers for Medicare & Medicaid Services. CY 2024 OPPS Final Rule Home Page.

g. Medicare national average payment is determined by multiplying the APC weight by the conversion factor of $87.382 for CY 2024, which assumes that hospitals meet reporting requirements of the Hospital Outpatient Quality Reporting Program: CY 2024 OPPS Final Rule Home Page.

h. Centers for Medicare & Medicaid Services. CY 2024 ASC Final Rule Home Page.

i. Medicare national average payment is determined by multiplying the ASC weight by the conversion factor of $53.514 for CY 2024, which assumes the ASC meets reporting requirements. CY 2024 ASC Final Rule Home Page.

j. https://www.cms.gov/medicare/coding-billing/icd-10-codes/2024-icd-10-pcs.

k. Centers for Medicare & Medicaid Services. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2024-ipps-final-rule-home-page FY 2024 IPPS Final Rule Home Page

l. Payment is based on the average standardized operating amount ($6,497.77) plus the capital standard amount ($503.83). The payment rate shown is the standardized amount for facilities with a wage index greater than one. The average standard amounts shown also assume facilities receive the full quality update. FY 2024 IPPS Final Rule Home Page

Coding footnotes

1. The provider may report only one primary procedure code plus the add-on code +22515 for each additional level regardless of whether the additional level(s) are contiguous or not, per National Correct Coding Initiative (NCCI) Policy Manual 1/1/2024, Chapter IV, F.4.
2. Endovascular Today, May 2017, "Vertebroplasty and Vertebral Augmentation Coding Revisited", http://evtoday.com/2017/05/vertebroplasty-and-vertebral-augmentation-coding-revisited?center=123
3. Notwithstanding the code definition, C1713 also applies to "synthetic bone substitutes that may be used to fill bony void or gaps (ie, bone substitute implanted into a bony defect created from trauma or surgery)". Medicare Claims Processing Manual, Chapter 4-Hospital Outpatient, Section 60.4.3. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf . In particular, note that code C1734, Orthopedic/device/drug matrix for apposing bone-to-bone or soft tissue-to bone (implantable), is reserved for a type of augmented bone graft used in ankle fusion procedures. January 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS), p.4 https://www.cms.gov/files/document/r4513cp.pdf.
4. Status Indicator (SI) shows how a code is handled for payment purposes: J1 = paid under comprehensive APC, single payment based on primary service without separate payment for other adjunctive services; N = packaged service, no separate payment.
5. The Payment Indicator shows how a code is handled for payment purposes. J8 = device-intensive procedure, payment amount adjusted to incorporate device cost; G2 = surgical procedure, non-office-based, payment based on hospital outpatient rate adjusted for ASC; N1 = packaged service, no separate payment.
6. ICD-10-CM and ICD-10-PCS Coding Handbook 2022, Central Office on ICD-10-CM and ICD-10-PCS of the American Hospital Association, Chapter 22, Vertebroplasty and Kyphoplasty, p.318-319.
7. Coding Clinic, 2nd Q 2014, p.12.

8. W MCC in MS-DRG titles refers to secondary diagnosis codes that are designated as major complications or comorbidities. MS-DRGs W MCC have at least one major secondary complication or comorbidity. Similarly, W CC in MS-DRG titles refers to secondary diagnosis codes designated as other (non-major) complications or comorbidities, and MS-DRGs W CC have at least one other (non-major) secondary complication or comorbidity. MS-DRGs W/O CC/MCC have no secondary diagnoses that are designated as complications or comorbidities, major or otherwise. Note that some secondary diagnoses are only designated as CCs or MCCs when the conditions were present on admission, and do not count as CCs or MCCs when the conditions are acquired in the hospital during the stay.

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