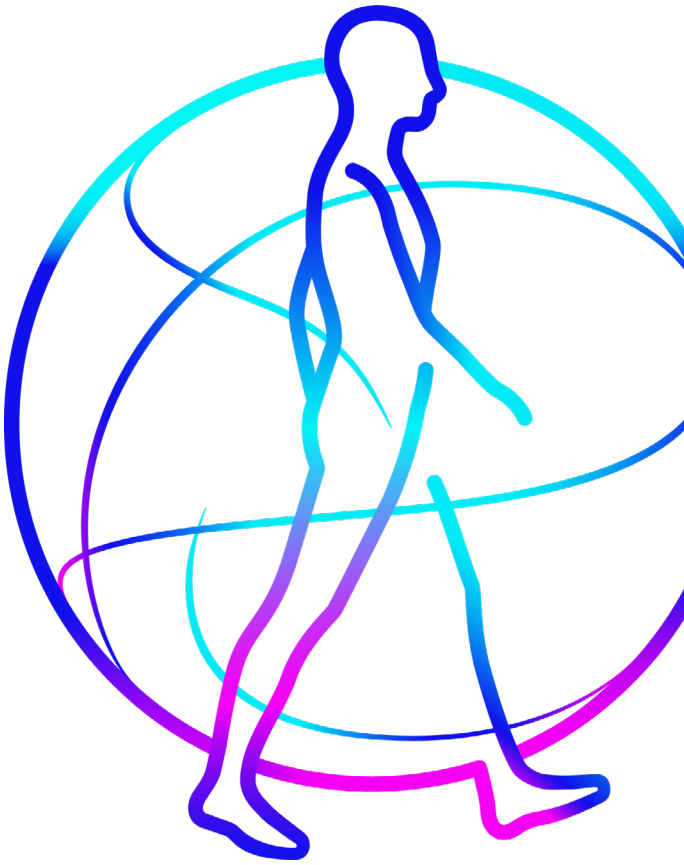
Medtronic



Vertebroplasty system

2024 Coding and payment guide

What's inside:

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
22510[d]	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic	7.90	$1,749	$420
22511[d]	- lumbosacral[1]	7.33	$1,747	$395
+22512	- each additional cervicothoracic or lumbosacral vertebral body[2]	4.00	$709	$201

Multiple Procedures:
The vertebroplasty 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 +22512 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[a]	APC[f]	APC level	Status indicator[f,4]	Relative weight[f]	Medicare national average[f,g]
22510	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic	5113	Level 3	J1	35.3304	$3,087
22511	- lumbosacral[1]	5113	Level 3	J1	35.3304	$3,087
+22512	- each additional cervicothoracic or lumbosacral vertebral body[2]	-	-	N	-	-
22510 **plus** **+25112**	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic - each additional cervicothoracic or lumbosacral vertebral body[2]	5114	Level 4	J1	78.0873	$6,823
22511 **plus** **+25112**	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral - each additional cervicothoracic or lumbosacral vertebral body[2]	5114	Level 4	J1	78.0873	$6,823

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,i]
22510	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic	G2	Y	28.3844	$1,519
22511	- lumbosacral[1]	G2	Y	28.3844	$1,519
+22512	- each additional cervicothoracic or lumbosacral vertebral body[2]	N1	N/A	N/A	N/A
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	G2	Y	63.4042	$3,393
C7505	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	G2	Y	63.4042	$3,393

Billing multiple Vertebroplasty levels:

Medicare:
ASC complexity C-codes C7504-C7505 should be assigned to report multi-level Vertebroplasty. CPT codes 22510-22512 for multi-level Vertebroplasty should not be reported to Medicare.

Commercial Payers:
ASCs should check with the specific commercial payer to determine whether C7504-C7505 are to be reported for multi-level Vertebroplasty procedures or whether CPT codes 22510-22512 should be reported.

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Hospital inpatient coding and payment

Effective October 1, 2023 – September 30, 2024

Vertebroplasty
The following ICD-10-PCS codes are assigned for vertebroplasty procedures. Root operation U-Supplement is used for vertebroplasty and device value J-Synthetic Substitute is used for the cement.[6,7]

ICD-10-PCS[j] procedure codes	ICD-10-PCS procedure code description
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

Biopsy of vertebra
Vertebral biopsy is sometimes performed together with kyphoplasty and is coded separately in ICD-10-PCS.[6] 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 the diagnosis codes commonly found on Medicare LCDs and LCAs. Other DRGs may be available for payers that accept additional diagnosis codes.

Vertebroplasty for pathological fractures due to osteoporosis or malignancy
When patients are admitted for pathological fracture due to osteoporosis or malignancy and vertebroplasty 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

Vertebroplasty 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. Code 22511 is used for vertebroplasty of the lumbar vertebrae and sacral vertebrae per CPT Assistant April 2015, p. 8.

2. The provider may report only one primary procedure code plus the add-on code +22512 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.

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. 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.