



Hospital Outpatient Coding and Payment

The Medicare prospective payment system is based upon clinically similar procedure groups called Ambulatory Payment Classifications (APC). Appropriate CPT codes are used to describe procedures performed and these map to the appropriate APC group. Reimbursement rates shown are the Medicare national average payments for 2009 and do not represent actual payments made to individual providers as payments are adjusted specifically to geographic regions. All information is subject to change without notice and the provider should check with the local carrier regarding the specific region and appropriate provider policy and payment amount. The reimbursement information in this document pertains to Medicare and does not specifically apply to private insurers. Providers should refer to the individual private insurer negotiated contracts regarding policy and payments.

Vertebral Augmentation Procedures³

CPT Code ¹	Description	APC	Status Indicator ²	Medicare National Unadjusted Payment
22520	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic	050	T	\$1,973.95
22521	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; lumbar	050	T	\$1,973.95
22522	Each additional thoracic or lumbar vertebral body	050	T	\$986.97*
22523	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (e.g., kyphoplasty); thoracic	052	T	\$5,720.43
22524	Lumbar	052	T	\$5,720.43
22525	Each additional thoracic or lumbar vertebral body	052	T	\$2,860.21*
72291	Radiological supervision and interpretation, percutaneous vertebroplasty or vertebral augmentation including cavity creation, per vertebral body; under fluoroscopic guidance	N/A	N	N/A
72292	Under CT guidance	N/A	N	N/A

Discretionary Codes

20225 ⁴	Biopsy, bone, trocar, or needle; deep (e.g., vertebral body, femur)	021	T	\$1,050.17
22899 ⁵	Unlisted procedure, spine	049	T	\$1,438.83

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2 Status Indicator T: Significant procedure, multiple surgical reduction applies. Status Indicator N: Items and services packaged into APC rates.

3 Provider should consult coverage policy or contact payer for medical necessity requirements, cavity creation requirements, and appropriate use of coding, if any or applicable. Please refer to the Instructions for Use for product description and indications for use.

4 Bone biopsy performed at same level as primary procedure is not separately payable.

5 Procedure considered 'open' when not performed percutaneously. Procedure code excluded from payment in ASC setting.

* Multiple surgical reduction applied to Medicare national adjusted payment for additional level performed same day surgery.

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Vertebral Augmentation Procedures²

Effective January 2008, CMS expanded the ambulatory surgery list of allowable procedures and also made changes to the ASC payment system intending to phase it in over a four year period. Under the final ASC payment methodology rule, the revised payment rates will be based on a percentage of the ambulatory payment classifications (APC's), used to classify OPPS items and services. Reimbursement rates shown are the Medicare national amount for 2009 and do not represent actual payments made to individual providers as payments are adjusted specifically to geographic regions. All information is subject to change without notice and the provider should check with the local carrier regarding the specific region and appropriate provider payment amount. The reimbursement information in this document pertains to Medicare and does not specifically apply to private insurers. Providers should refer to the individual private insurer negotiated contracts regarding policy and payments.

ICD-9-CM

Procedure code ^{1,2}	Description
81.65	Percutaneous Vertebroplasty
81.66	Percutaneous Vertebral Augmentation

Possible MS-DRG3	Description	Medicare National Unadjusted Payment
515	Other musculoskeletal system and connective tissue O.R. procedures with MCC	\$17,029
516	Other musculoskeletal system and connective tissue O.R. procedures with CC	\$10,041
517	Other musculoskeletal system and connective tissue O.R. procedures without CC/MCC	\$7,381
907	Other O.R. procedures for injuries with MCC	\$20,436
908	Other O.R. procedures for injuries with CC	\$10,602
909	Other O.R. procedures for injuries without CC/MCC	\$6,298

ICD-9-CM Diagnosis codes⁴

Providers should always report the ICD-9-CM diagnosis codes that most accurately describe a patient's medical condition. The following codes may be appropriate for patients undergoing vertebroplasty or vertebral augmentation procedures. Please refer to specific payer policies for more information regarding indicated diagnoses; multiple diagnosis codes may be required.

- 733.13 Pathologic Fracture of Vertebrae
- 733.xx Osteoporosis Diagnoses
- 170.xx Malignant Neoplasm
- 198.5 Secondary malignant neoplasm of other specified sites; bone and bone marrow
- 203.xx Multiple Myeloma
- 213.xx Benign Neoplasm
- 238.xx Neoplasm of Uncertain Behavior
- 8xx.xx Fracture Diagnoses

1 Admission decisions should be based on medical necessity for each individual patient.

Physicians should be aware of facility admission criteria to ensure medical necessity of inpatient admissions.

2 Provider should consult coverage policy or contact payer for medical necessity requirements, cavity creation requirements, and appropriate use of coding, if any or applicable. Please refer to the Instructions for Use for product description and indications for use.

3 Payment may be made based on MS-DRG not listed, depending on patient's condition and services provided.

4 ICD-9 codes listed are for demonstration purposes only and are not exhaustive. Diagnosis code(s) should reflect a patient's specific medical condition(s). Provider should consult coverage policy or contact payer for information on ICD-9 codes that support medical necessity.

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Vertebral Augmentation Procedures³

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CPT Code ^{1,3}	Description	Status Indicator	Medicare National Unadjusted Payment
22520	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic	A2 ²	\$1,244.87
22521	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; lumbar	A2	\$1,244.87
22522	Each additional thoracic or lumbar vertebral body	A2	\$627.93*
22523	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (e.g., kyphoplasty); thoracic	G2 ⁴	\$3,495.21
22524	Lumbar	G2	\$3,495.21
22525	Each additional thoracic or lumbar vertebral body	G2	\$1,747.60*
72291	Radiological supervision and interpretation, percutaneous Vertebroplasty or vertebral augmentation including cavity creation, per vertebral body; under fluoroscopic guidance	N1	n/a
72292	Under CT guidance	A2	n/a

Discretionary Codes

20225 ⁶	Biopsy, bone, trocar, or needle; deep (e.g., vertebral body, femur)	A2	\$524.86
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2 Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight.

3 Provider should consult coverage policy or contact payer for medical necessity requirements, cavity creation requirements, and appropriate use of coding, if any or applicable.

- Please refer to the Instructions for Use for product description and indications for use.

4 Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight.

5 Packaged service/item; no separate payment made.

6 Bone biopsy performed at same level as primary procedure is not separately payable.

* Multiple surgical reduction applied to Medicare national adjusted payment for additional level performed same day surgery.

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Vertebral Augmentation Procedures²

Medicare payment for physician professional services are established by CPT codes according to a physician fee schedule and site of service (facility or non-facility). CPT codes are assigned a Relative Value Unit (RVUs) which consider factors such as practice expense, physician work and geographic area. All information is subject to change without notice and the provider should check with the local carrier regarding the specific region and appropriate provider policy and payment amount. The reimbursement information in this document pertains to Medicare and does not specifically apply to private insurers. Providers should refer to individual private insurer negotiated contracts regarding coverage policy, coding and payments.

CPT Code ^{1,2}	Description	Global Period	Medicare National Unadjusted Payment	
			Facility	Non-Facility
22520	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic	010	\$554.34	\$2,091.86
22521	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; lumbar	010	\$522.24	\$2,036.68
22522	Each additional thoracic or lumbar vertebral body	ZZZ	\$224.89	\$224.89
22523	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (e.g., kyphoplasty); thoracic	010	\$579.59	\$579.59
22524	Lumbar	010	\$554.70	\$554.70
22525	Each additional thoracic or lumbar vertebral body (list separately in addition to code for primary procedure)	ZZZ	\$260.04	\$260.04
72291	Radiological supervision and interpretation, percutaneous Vertebroplasty or vertebral augmentation including cavity creation, per vertebral body; under fluoroscopic guidance	XXX	\$260.04	\$260.04
72292	Under CT guidance	XXX	\$69.25	\$69.25

ICD-9-CM Diagnosis Codes⁵

Providers should always report the ICD-9-CM diagnosis codes that most accurately describe a patient's medical condition. Please refer to specific payer policies for more information regarding indicated diagnoses; multiple diagnosis codes may be required. The following diagnosis codes may apply and are for demonstration purposes only and are not exhaustive.

- 733.13 Pathologic Fracture of the Vertebrae
- 733.XX Osteoporosis Diagnoses
- 170.XX Malignant Neoplasm
- 2XX.XX Neoplasm; Deficiency-Related Diagnoses
- 8XX.XX Fracture Diagnoses

Documentation

Medical record documentation is essential to determine whether a procedure is reasonable and necessary for the patient. Medical record documentation should provide a detailed history, physical and procedure overview to verify that a claim has been coded specifically and accurately. See payer policy for specific documentation and clinical coverage criteria as an example some payers may require that conservative care has been tried and failed. Medical necessity will dictate site of service for each individual patient. Please contact your medical facility for inpatient admission criteria.

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 4 Procedure should be submitted as 'open' when not performed percutaneously. Procedure code excluded from payment in ASC setting.
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