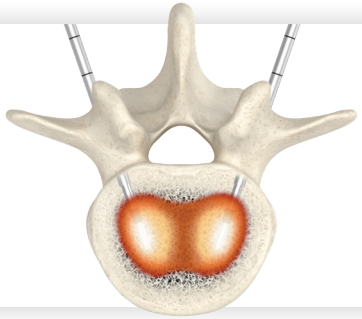
2022 reimbursement guide | vertebral body ablation

OptaBlate™ radiofrequency generator system



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		Physician fees[2]		Relative value units (RVUs)[2]			Hospital outpatient			Ambulatory surgery center (ASC)	
CPT code[1]	Description	Payment in office	Payment in facility	Non-facility RVUs	Facility RVUs	Work RVUs	Device codes[5]	Ambulatory payment classification (APC)	APC payment[3]	ASC payment[4]	ICD-10-CM diagnosis codes[6]
Ablation											
20982	Ablation therapy for reduction or eradication of 1 or more bone tumors (e.g., metastasis), including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency	$3,751	$369	108.38	10.67	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)	5114	$6,397	$2,998	**D16.6 –** Benign neoplasm of vertebral column **D16.8 –** Benign neoplasm of pelvic bones, sacrum, and coccyx
Cementoplasty											
21899	Unlisted procedure, neck or thorax	Contractor priced	Contractor priced	N/A	N/A		N/A	N/A	N/A	N/A	N/A
27299	Unlisted procedure, pelvis or hip joint										
Biopsy of bone											
20225	Biopsy, bone, trocar, or needle, deep (e.g., vertebral body, femur)	$410	$131	11.85	3.79	2.45	N/A	5072	$1,437	$608	N/A
Vertebroplasty											
22510	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic	$1,943	$438	56.14	12.65	7.90	N/A	5113	$2,892	$1,360	N/A
22511	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral	$1,940	$413	56.05	11.92	7.33					
22512	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure)	$780	$210	22.54	6.06	4.00	N/A	N/A	Packaged	Packaged	N/A

		Physician fees[2]		Relative value units (RVUs)[2]			Hospital outpatient			Ambulatory surgery center (ASC)	
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Vertebral augmentation											
22513	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., vertebral augmentation), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic	$6,214	$519	179.55	15.01	8.65	N/A	5114	$6,397	$2,998	N/A
22514	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., vertebral augmentation), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar	$6,183	$483	178.67	13.97	7.99			$6,397	$2,998	
22515	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., vertebral augmentation), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body	$3,199	$222	92.45	6.42	4.00		N/A	Packaged	Packaged	
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	N/A	Contractor priced	N/A	Contractor priced	N/A		5114	$6,397	$3,903	
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	Carrier priced	Carrier priced	N/A	Contractor priced	N/A			$6,397	$2,998	

Notes

When bone tumor ablation and vertebral augmentation are performed during the same session, the two coded procedures qualify for a complexity adjustment. When 20982 and 22513 or 22514 are coded together, they map to APC 5115. When coded alone, 20982 and 22513 or 22514 map to APC 5114.

Multiple procedures

RF ablation and biopsy codes are subject to multiple procedure payment reduction when billed together during a single patient encounter. 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.

ICD-10-PCS procedure codes[6]

Ablation: Vertebrae and spine	
0P543ZZ	Destruction of thoracic vertebra, percutaneous approach
0Q503ZZ	Destruction of lumbar vertebra, percutaneous approach
Cementoplasty: Vertebrae and spine	
0PU43JZ	Supplement of thoracic vertebra with synthetic substitute, percutaneous approach
0QU03JZ	Supplement of lumbar vertebra with synthetic substitute, percutaneous approach
Biopsy of bone: Vertebrae and spine	
0PB43ZX	Excision of thoracic vertebra, percutaneous approach, diagnostic
0Q503ZZ	Excision of lumbar vertebra, percutaneous approach, diagnostic
Vertebroplasty	
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
Vertebral augmentation	
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

Medicare severity diagnosis-related groups (MS-DRGs)[7]

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*	$24,016
496	Local excision and removal of internal fixation devices except hip and femur W CC**	$13,099
497	Local excision and removal of internal fixation devices except hip and femur WO CC/MCC***	$9,572
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	$24,016
496	Local excision and removal of internal fixation devices except hip and femur W CC	$13,099
497	Local excision and removal of internal fixation devices except hip and femur WO CC/MCC	$9,572
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	$22,149
478	Biopsies of musculoskeletal system and connection tissue W CC	$15,552
479	Biopsies of musculoskeletal system and connection tissue WO CC/MCC	$11,932

ICD-10-CM diagnosis codes[6]

Major osseous defect (vertebroplasty, vertebral augmentation)	
M89.78	Major osseous defect, other site
Pathological fracture (vertebroplasty, vertebral augmentation)	
M84.58xA	Pathological fracture in neoplastic disease, other specified site, initial encounter

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

References

1. Current Procedural Terminology 2022, American Medical Association. Chicago, IL 2021. CPT is a registered trademark of the American Medical Association. Current Procedural Terminology (CPT®) is copyright 2021 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
2. CMS-1751-F, Addendum BF
3. CMS-1753-FC, Addendum B
4. CMS-1753-FC, Addenda
5. Device Category Codes. Medicare Claims Processing Manual, Chapter 4 Section 60.4.2
6. ICD-10-PCS and ICD-10-CM https://www.cms.gov/icd10m/version37-fullcode-cms/fullcode_cms/P0001.html
7. CMS-1752-F2

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 or 22514, 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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