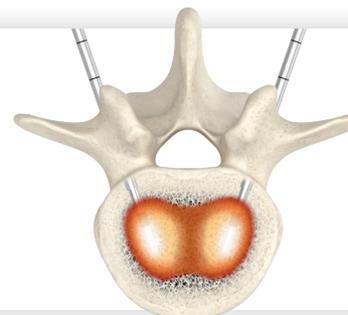


## 2022 reimbursement guide | vertebral body ablation

# OptaBlate™ radiofrequency generator system



**stryker**

CPT code <sup>1</sup>	Description	Physician fees <sup>2</sup>		Relative value units (RVUs) <sup>2</sup>			Hospital outpatient			Ambulatory surgery center (ASC)	ICD-10-CM diagnosis codes <sup>6</sup>
		Payment in office	Payment in facility	Non-facility RVUs	Facility RVUs	Work RVUs	Device codes <sup>5</sup>	Ambulatory payment classification (APC)	APC payment <sup>3</sup>	ASC payment <sup>4</sup>	
<b>Ablation</b>											
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	<b>Ablation catheter C1886</b> Catheter, extravascular tissue ablation, any modality (insertable) <b>Cement C1713</b> Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)	5114	\$6,397	\$2,998	<b>D16.6</b> – Benign neoplasm of vertebral column <b>D16.8</b> – Benign neoplasm of pelvic bones, sacrum, and coccyx
<b>Cementoplasty</b>											
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										
<b>Biopsy of bone</b>											
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
<b>Vertebroplasty</b>											
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

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<b>Vertebral augmentation</b>											
<b>22513</b>	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
<b>22514</b>	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	
<b>22515</b>	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	
<b>0200T</b>	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	
<b>0201T</b>	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.

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## ICD-10-PCS procedure codes<sup>6</sup>

Ablation: Vertebrae and spine	
<b>0P543ZZ</b>	Destruction of thoracic vertebra, percutaneous approach
<b>0Q503ZZ</b>	Destruction of lumbar vertebra, percutaneous approach
Cementoplasty: Vertebrae and spine	
<b>0PU43JZ</b>	Supplement of thoracic vertebra with synthetic substitute, percutaneous approach
<b>0QU03JZ</b>	Supplement of lumbar vertebra with synthetic substitute, percutaneous approach
Biopsy of bone: Vertebrae and spine	
<b>0PB43ZX</b>	Excision of thoracic vertebra, percutaneous approach, diagnostic
<b>0Q503ZZ</b>	Excision of lumbar vertebra, percutaneous approach, diagnostic
Vertebroplasty	
<b>0PU43JZ</b>	Supplement thoracic vertebra with synthetic substitute, percutaneous approach
<b>0QU03JZ</b>	Supplement lumbar vertebra with synthetic substitute, percutaneous approach
<b>0QU13JZ</b>	Supplement sacrum with synthetic substitute, percutaneous approach
Vertebral augmentation	
<b>0PS43ZZ</b>	Reposition thoracic vertebra, percutaneous approach
<b>plus 0PU43JZ</b>	Supplement thoracic vertebra with synthetic substitute, percutaneous approach
<b>0QS03ZZ</b>	Reposition lumbar vertebra, percutaneous approach
<b>plus 0QU03JZ</b>	Supplement lumbar vertebra with synthetic substitute, percutaneous approach
<b>0QS13ZZ</b>	Reposition sacrum, percutaneous approach sacrum, percutaneous
<b>plus 0QU13JZ</b>	Supplement sacrum with synthetic substitute, percutaneous approach

## Medicare severity diagnosis-related groups (MS-DRGs)<sup>7</sup>

Code	Description	Medicare national payment
<b>Ablation of bone neoplasm:</b> thorax (metastases only), vertebrae and spine, shoulder and upper arm, pelvis and lower leg		
<b>495</b>	Local excision and removal of internal fixation devices except hip and femur W MCC*	\$24,016
<b>496</b>	Local excision and removal of internal fixation devices except hip and femur W CC**	\$13,099
<b>497</b>	Local excision and removal of internal fixation devices except hip and femur WO CC/MCC***	\$9,572
<b>Ablation and cementoplasty of bone neoplasm:</b> thorax (metastases only), vertebrae and spine, shoulder (scapula), pelvis		
<b>495</b>	Local excision and removal of internal fixation devices except hip and femur W MCC	\$24,016
<b>496</b>	Local excision and removal of internal fixation devices except hip and femur W CC	\$13,099
<b>497</b>	Local excision and removal of internal fixation devices except hip and femur WO CC/MCC	\$9,572
<b>Ablation and biopsy of bone neoplasm:</b> thorax (metastases only), vertebrae and spine, shoulder and upper arm, pelvis, upper leg and lower leg		
<b>477</b>	Biopsies of musculoskeletal system and connection tissue W MCC	\$22,149
<b>478</b>	Biopsies of musculoskeletal system and connection tissue W CC	\$15,552
<b>479</b>	Biopsies of musculoskeletal system and connection tissue WO CC/MCC	\$11,932

## ICD-10-CM diagnosis codes<sup>6</sup>

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

\* Major complication or comorbidity

\*\* Complication or comorbidity

\*\*\* Complication or comorbidity/major complication or comorbidity

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## 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](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](mailto:IVS-reimbursement@stryker.com)**

## Interventional Spine

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