## Percutaneous vertebral augmentation with the SpineJack® system

Possible coding options and Medicare payment rates

<table>
<thead>
<tr>
<th>CPT code¹</th>
<th>Description</th>
<th>Physician²</th>
<th>Relative Value Units (RVUs)</th>
<th>ICD-10 diagnosis codes⁶</th>
<th>Hospital outpatient³</th>
<th>Ambulatory surgery center³</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Payment in office</td>
<td>Payment in facility</td>
<td>Non-facility</td>
<td>Facility</td>
<td>Possible device code(s)⁴</td>
</tr>
<tr>
<td>22513</td>
<td>Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic</td>
<td>$7,047.45</td>
<td>$539.14</td>
<td>195.56</td>
<td>14.96</td>
<td>C41.2 Malignant neoplasm of vertebral column, C79.51, C75.52 Secondary malignant neoplasm of bone and bone marrow; code range C1819 Implantable/insertable device, not otherwise classified</td>
</tr>
<tr>
<td>22514</td>
<td>Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar</td>
<td>$7,024.74</td>
<td>$502.39</td>
<td>194.92</td>
<td>13.94</td>
<td>C90.00, C90.02 Multiple myeloma; code range D18.09 Hemangioma of other sites</td>
</tr>
<tr>
<td>22515</td>
<td>Each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)</td>
<td>$4,077.82</td>
<td>$232.81</td>
<td>113.15</td>
<td>6.46</td>
<td>M48.50, M48.58 Collapsed vertebra, not elsewhere classified; code range M80.08 Age related osteoporosis with current pathological fracture, vertebra(e) M84.48 Pathological fracture, other site M84.58 Pathological fracture in neoplastic disease, other specified site M84.68 Pathological fracture in other disease, other site</td>
</tr>
</tbody>
</table>

---

**Reimbursement Solutions**

Questions? **855 899 9901**
(Monday - Friday, 7am - 5pm MT)

reimbursement.strykerIVS.com

helpdesk@strykerIVS.com
**MS-DRGS**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>515</td>
<td>Other musculoskeletal SYS and CONN TISS O.R. proc w MCC</td>
<td>$18,817.12</td>
</tr>
<tr>
<td>516</td>
<td>Other musculoskeletal SYS and CONN TISS O.R. proc w CC</td>
<td>$11,511.29</td>
</tr>
<tr>
<td>517</td>
<td>Other musculoskeletal SYS and CONN TISS O.R. proc w/o CC/MCC</td>
<td>$8,431.07</td>
</tr>
</tbody>
</table>

**References**


2. Note that the addenda containing the most recent relative value units and conversion factor used to calculate Medicare physician payment rates are available on the CMS web site, via the link for Physician Fee Schedule Addendum B at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1676-F.html

Medicare national average physician payment rates listed in this document are based on the November 2018 release of the relative value file and conversion factor of $36.0391.

3. The addenda containing relative weights, payment rates, wage indices, and other payment information are no longer printed in the Federal Register. Instead, the addenda are available only on the CMS web site. Addenda relating to the OPPS are available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices/PPS-Addenda-Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1678-FC.html under the OPPS Addenda tab and addenda relating to the ASC payment system are on the same link under "Final Changes to the Ambulatory Surgical Center Payment System and CY 2019 Payment Rates."


5. The CY2015 CMS OPPS Final Rule bundled add-on code payment into the primary procedure payment.


7. CMS FY2019 IPPS Final Rule. Note that the tables containing the most recent standardized amounts and Medicare Severity Diagnosis Related Group (MS-DRG) relative weights used to calculate IPPS payment rates are available on the CMS web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientIPPS/FY2019-IPPS-Final-Rule-Home-Page.html

**Notes**

- "N/A" indicates that this concept does not apply, or that Medicare has not developed fee schedules in those settings of care.
- AMA Guidance: The percutaneous vertebroplasty and vertebral augmentation section in the CPT 2015 includes new guidelines to clarify the appropriate reporting of these procedures. From a CPT coding perspective and for the purposes of reporting, codes 22510, 22511, and 22512 describe vertebroplasty, which is defined as the process of injecting a material (cement) into the vertebral body using image guidance to reinforce the structure of the vertebral body. Codes 22513, 22514, and 22515 describe vertebral augmentation (eg, kyphoplasty), which is the process of mechanical cavity creation within the vertebral body followed by the injection of the material (cement) under image guidance. Based on the two definitions, the distinction between the two procedures is whether a cavity is created in the vertebral body. Sacral augmentation (sacroplasty), which is reported with category III codes 0200T and 0201T, creating a cavity (ie, kyphoplasty) would then be reported with code 0200T, percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used, one or more needles, includes imaging guidance and bone biopsy, when performed, or code 0201T, percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, two or more needles, includes imaging guidance and bone biopsy, when performed, depending on whether unilateral or bilateral cavity creation and cement injection was performed.

CPT codes 22513 and 22514 are by definition single level procedure codes. Procedures performed on more than one level should be reported with the appropriate number of units using CPT code 22515. The percutaneous vertebral augmentation codes are not bilateral eligible.

C-codes are reported to Medicare for medical devices in the outpatient setting.

The information provided is general reimbursement information only; it is not legal advice, nor is it advice about how to code, complete or submit any particular claim for payment. Although we supply this information to the best of our current knowledge, it is always the provider’s responsibility to determine and submit appropriate codes, charges, modifiers and bills for services that were rendered. This information is provided as of December 2018 and all coding and reimbursement information is subject to change without notice.

Reimbursement has three components, coding, coverage and payment. All three must be aligned for providers to receive reimbursement for the services they furnish.

Payment rates are calculated and represent the national unadjusted payments rates. Payment to individual providers will vary based on a number of variables, including geographic location.

It is important to note that coverage will vary based upon individual patient medical necessity and specific payer coverage policies. Stryker cannot guarantee coverage or payment for products or procedures. Please contact your Medicare Administrative Contractor or Private Payer for billing, payment and coverage information.

**Indications for use**

VertaPlex HV bone cement is indicated for the fixation of pathological fractures of the vertebral body using vertebroplasty or kyphoplasty. It is also indicated for the fixation of pathological fractures of the sacral vertebral body or ala using sacral vertebroplasty or sacroplasty. Painful vertebral compression fractures may result from osteoporosis, benign lesions (hemangioma), and malignant lesions (metastatic cancers, myeloma).