

Vertebroplasty

2009 CODING AND REIMBURSEMENT GUIDE

Coverage, coding and payment for medical procedures and devices can be confusing. This guide was developed to assist with Medicare reporting and reimbursement for vertebroplasty procedures.

Coverage

Medicare carriers may issue local coverage decisions (LCDs) listing criteria that must be met prior to coverage. Physicians are urged to review these policies (<http://www.cms.hhs.gov/mcd/search.asp?>), and are encouraged to contact their local carrier medical director (www.cms.hhs.gov/apps/contacts) or commercial insurers to determine if a procedure is covered.

Coding

Vertebroplasty procedures are typically reported using the following CPT® code(s):

Procedure Codes

22520	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic
22521	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; lumbar
+22522	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)

Radiologic Supervision and Interpretation Codes

72291	Radiological supervision and interpretation, percutaneous vertebroplasty or vertebral augmentation including cavity creation, per vertebral body; under fluoroscopic guidance
72292	Radiological supervision and interpretation, percutaneous vertebroplasty or vertebral augmentation including cavity creation, per vertebral body; under CT guidance

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Disclaimer: The information provided herein reflects Cook's understanding of the procedure(s) and/or device(s) from sources which may include, but are not limited to, the CPT, ICD-9 and MS-DRG coding systems; Medicare payment systems; commercially available coding guides; professional societies; and research conducted by independent coding and reimbursement consultants. This information should not be construed as authoritative. The entity billing Medicare and/or third party payers is solely responsible for the accuracy of the codes assigned to the services and items in the medical record. Cook does not, and should not, have access to medical records, and therefore cannot recommend codes for specific cases. When making coding decisions, we encourage you to seek input from the AMA, AHA, relevant medical societies, CMS, your local Medicare Administrative Contractor and other health plans to which you submit claims. Cook does not promote the off-label use of its devices.

Payment

2009 Medicare Reimbursement for Percutaneous Vertebroplasty in the Outpatient Setting

Code	Procedure Description	Ambulatory Surgery Center	Outpatient Hospital		Physician Services	
		Facility Fee ¹	APC	Facility Fee (National Medicare Avg ²)	Fee When Procedure Is Performed in Hospital or ASC (National Medicare Avg ³)	Fee When Procedure Is Performed in Office (National Medicare Avg ³)
22520	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic	\$1,255.87	0050	\$1,973.95	\$554.34	\$2,091.86
22521	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; lumbar	\$1,255.87	0050	\$1,973.95	\$522.24	\$2,036.68
+22522	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)	\$627.94 Multiple procedure reduction applied	0050	\$986.98 Multiple procedure reduction applied	\$244.89	\$244.89
72291	Radiological supervision and interpretation, percutaneous vertebroplasty or vertebral augmentation including cavity creation, per vertebral body; under fluoroscopic guidance	Imaging is included in payment for vertebroplasty services		Imaging is included in payment for vertebroplasty procedure	\$69.25	Carrier priced procedure
72292	Radiological supervision and interpretation, percutaneous vertebroplasty or vertebral augmentation including cavity creation, per vertebral body; under CT guidance	Imaging is included in allowance for vertebroplasty services		Imaging is included in allowance for vertebroplasty procedure	\$71.77	Carrier priced procedure

1. 2009 Medicare Ambulatory Surgery Center Fee Schedule
2. 2009 Medicare Hospital Outpatient Prospective Payment System (OPPS) Fee Schedule
3. 2009 Medicare Physician Fee Schedule

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2009 physician fees for your local area can be found at the following CMS links:

http://www.cms.hhs.gov/PFSlookup/02_PFSsearch.asp#TopOfPage

or

<http://www.cms.hhs.gov/PhysicianFeeSched/PFSNPAF/list.asp#TopOfPage>



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