Vertebroplasty

2012 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 when using Cook bone biopsy needles.

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 encouraged to contact their local carrier medical directors (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 (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; thoracic
22521	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; lumbar
+22522	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure) (Do not report 22520-22522 in conjunction with 20225, 22310-22315, 22325, 22327 when performed at the same level as 22520-22522)

Radiological Supervision and Interpretation Codes

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

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Payment

2012 Reimbursement for Percutaneous Vertebroplasty in the Outpatient Setting

		Ambulatory Surgery Center	*Outpatient Hospital*		*Physician Services*	
CPT® Code	Procedure Description	Facility Fee (National Medicare Avg[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 (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; thoracic	$1,308.04	0050	$2,267.06	$512.61	$2,252.95
22521	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; lumbar	$1,308.04	0050	$2,267.06	$487.76	$2,242.40
+22522	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure) (Do not report 22520-22522 in conjunction with 20225, 22310-22315, 22325, 22327 when performed at the same level as 22520-22522)	$654.02 Multiple procedure reduction applied	0050	$1,133.53 Multiple procedure reduction applied	$226.69	N/A*
72291	Radiological supervision and interpretation, percutaneous vertebroplasty, vertebral augmentation, or sacral augmentation (sacroplasty), including cavity creation, per vertebral body or sacrum; under fluoroscopic guidance	Imaging is included in payment allowance for vertebroplasty services	Imaging is included in payment allowance for vertebroplasty services		$71.82	Carrier-priced procedure
72292	Radiological supervision and interpretation, percutaneous vertebroplasty, vertebral augmentation, or sacral augmentation (sacroplasty), including cavity creation, per vertebral body or sacrum; under CT guidance	Imaging is included in payment allowance for vertebroplasty services	Imaging is included in payment allowance for vertebroplasty services		$72.84	Carrier-priced procedure

1. 2012 Medicare Ambulatory Surgery Center Fee Schedule
2. 2012 Medicare Hospital Outpatient Prospective Payment System Fee Schedule
3. 2012 Medicare Physician Fee Schedule

*Medicare has not developed a rate for the in-office setting because these procedures are typically performed in a hospital setting. Physicians should contact the Medicare contractor to determine if the service can be performed in office. If the contractor determines the service or procedure may be performed in office, the physician will received Medicare's physician fee schedule amount for procedures performed in the hospital/ASC.

2012 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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Disclaimer: The information provided herein reflects Cook's understanding of the procedure(s) and/or device(s) from sources that 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 you are 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.

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