

Coding Guide for Vertebral Augmentation Procedures

Site of Service Codes

Office - 11	Inpatient - 21	Outpatient - 22	Ambulatory Surgical Center - 24
Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness, or injury on an ambulatory basis.	A facility, other than psychiatric, which primarily provides diagnosis, therapeutic, (both surgical and non-surgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of reasons.	A portion of the hospital which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

Coding for Hospital Outpatient/ASC Coding for Hospital Inpatient

CPT Code	Description	Ambulatory Payment Classification (APC)
22520	Percutaneous vertebroplasty, one vertebral body; unilateral or bilateral injection; thoracic	APC 0050
22521	Percutaneous vertebroplasty, one vertebral body; unilateral or bilateral injection; lumbar	APC 0050
22522	each additional thoracic or lumbar vertebral body	APC 0050
22523	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic	APC 0052
22524	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); lumbar	APC 0052
22525	each additional thoracic or lumbar vertebral body	APC 0052
72291	Radiological supervision & interpretation, percutaneous vertebroplasty or vertebral augmentation including cavity creation, per vertebral body; under fluoroscopic guidance	N/A
72292	Radiological supervision & interpretation, percutaneous vertebroplasty or vertebral augmentation including cavity creation, per vertebral body; under CT guidance	N/A

MS-DRG	Description
515	Other musculoskeletal system & connective tissue O.R. procedures w Major Complication or Comorbidity (MCC)
516	Other musculoskeletal system & connective tissue O.R. procedures w/ (CC)
517	Other musculoskeletal system & connective tissue O.R. procedures (w/o CC/MCC)
907	Other O.R. Procedures for Injuries (with MCC)
908	Other O.R. Procedures for Injuries (with CC)
909	Other O.R. Procedures for Injuries (without CC/MCC)



Hospital Inpatient Procedure Codes

ICD-9-CM	Description
81.65	<u>Percutaneous Vertebroplasty</u> Injection of bone void filler (cement) (polymethylmethacrylate) (PMMA) into the diseased or fractured vertebral body.
81.66	<u>Percutaneous Vertebral Augmentation</u> Insertion of inflatable balloon, bone tamp, or other device displacing (removing) (compacting) bone to create a space (cavity) (void) prior to the injection of bone void filler (cement) (polymethylmethacrylate) (PMMA) or other substance. (Arcuplasty, Kyphoplasty, SKyphoplasty, Spineoplasty)

Commonly Used Diagnosis Codes

ICD-9-CM	Description	ICD-9-CM	Description	ICD-9-CM	Description
170.2	Malignant neoplasm of vertebral column excluding sacrum and coccyx	213.2	Benign neoplasm of vertebral column excluding sacrum and coccyx	733.09	Other osteoporosis
198.5	Secondary malignant neoplasm of bone and bone marrow	228.09	Hemangioma of other sites	733.13	Pathological fracture of vertebrae
238.0	Neoplasm of uncertain behavior of bone and articular cartilage	238.0	Neoplasm of uncertain behavior of bone and Articular cartilage	733.82	Nonunion of fracture
808.00 - 805.08	Closed fracture of cervical vertebra unspecified level - closed fracture of multiple cervical vertebrae	277.89	Other specified disorders of metabolism	805.00 - 805.08	Closed fracture of cervical vertebra unspecified level - closed fracture of multiple cervical vertebrae
805.3	Open fracture of dorsal (thoracic) vertebra without spinal cord injury	733.00	Osteoporosis - unspecified	805.10 - 805.18	Open fracture of cervical vertebra unspecified level - open fracture of multiple cervical vertebrae
203.00	Multiple myeloma, w/o mention of having achieved remission	733.01	Osteoporosis - senile	805.2	Closed fracture of dorsal (thoracic) vertebra without spinal cord injury
203.01	Multiple myeloma in remission	733.02	Osteoporosis - Idiopathic	805.3	Open fracture of dorsal (thoracic) vertebra without spinal cord injury
203.02	Multiple myeloma in relapse	733.03	Osteoporosis - Disuse	805.5	Open fracture of lumbar vertebra without spinal cord injury

Refer to the Local Medicare Carrier or CMS for specific guidance on covered codes. For a full list of site of service codes please refer to the CMS website at: <http://www.cms.hhs.gov/>

Documentation must validate the medical reasonableness and necessity of the procedure. When the documentation does not meet the criteria for the service rendered or the documentation does not establish the medical necessity for the services; such services will be denied as not reasonable and necessary. Under the MS-DRG system, procedures may be assigned to a number of other MS-DRG's, based on a particular patient's condition. Providers should report the codes that most accurately describe the patients' medical condition, procedures performed and the products used. DFine, Inc. cannot guarantee coverage or payment for products or procedures. The service and product must be reasonable and necessary for care of patient to support reimbursement. Providers should check Medicare bulletins, manuals, program memoranda, and Medicare guidelines to ensure compliance with Medicare requirements.



Redefining the Treatment of Vertebral Compression Fractures