### Percutaneous Vertebroplasty

#### Procedure Coding & Billing Reference

**CPT codes 22520 and 22521 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 22522. The percutaneous vertebroplasty codes are not bilateral eligible.**

#### If percutaneous vertebroplasty codes 22520 and 22521 are billed in conjunction with other procedures by the physician or hospital, multiple procedure reductions (MPR) may apply. (When two or more MPR eligible codes are billed on the same date of service, the most intense procedure is reimbursed at 100% of the code’s fee schedule. Additional MPR eligible procedures are paid at 50% of the code’s fee schedule.)

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

**Fluoroscopic guidance is packaged into other services provided in the hospital outpatient department and ambulatory surgery center.**

#### VertaPlex Radiopaque Bone Cement is indicated for the fixation of pathological fractures of the vertebral body using Vertebroplasty or Kyphoplasty procedures. Painful vertebral compression fractures may result from osteoporosis, benign lesions (hemangiomas), and malignant lesions (metastatic cancers, myeloma).

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 January 2011 and all coding and reimbursement information is subject to change without notice. QUESTIONS? CONTACT STRYKER REIMBURSEMENT SERVICES AT 1-866-496-4379.

1. **CPT code**
2. **Description**
3. **Physician**
   - **CPT code:** Payment in office
   - **CPT code:** Payment in facility
4. **Hospital Outpatient**
   - **Device code**
   - **APC**
   - **APC payment**
5. **Ambulatory Surgery Center**
   - **ASC payment**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Physician Payment in Office</th>
<th>Physician Payment in Facility</th>
<th>Hospital Outpatient Payment</th>
<th>Ambulatory Surgery Center Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>22520</td>
<td>Percutaneous vertebroplasty, 1 vertebral body, unilateral, or bilateral injection; thoracic</td>
<td>$2,229.53</td>
<td>$523.58</td>
<td>0050</td>
<td>$2,220.83</td>
</tr>
<tr>
<td>22521</td>
<td>Percutaneous vertebroplasty, 1 vertebral body, unilateral, or bilateral injection; lumbar</td>
<td>$2,187.40</td>
<td>$459.04</td>
<td>C1713</td>
<td>$2,220.83</td>
</tr>
<tr>
<td>22522</td>
<td>Each additional thoracic or lumbar vertebral body (list separately in addition to code for primary procedure)</td>
<td>$231.04</td>
<td>$231.04</td>
<td>0050</td>
<td>$2,220.83</td>
</tr>
<tr>
<td>72291-26</td>
<td>Radiological supervision and interpretation, percutaneous vertebroplasty or vertebral augmentation including cavity creation, per vertebral body, under fluoroscopic guidance</td>
<td>$72.71</td>
<td>$72.71</td>
<td>N/A</td>
<td>Packaged, not separately paid*</td>
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<tr>
<td>72292-26</td>
<td>Radiological supervision and interpretation, percutaneous vertebroplasty or vertebral augmentation including cavity creation, per vertebral body, under CT guidance</td>
<td>$74.75</td>
<td>$74.75</td>
<td>N/A</td>
<td>Packaged, not separately paid*</td>
</tr>
</tbody>
</table>

*N/A* indicates that this concept does not apply, or that Medicare has not developed fee schedules in those settings of care.

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