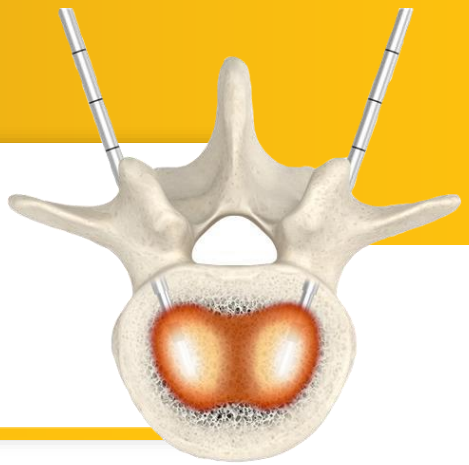
2026 reimbursement guide

Vertebral bone tumor ablation and multiple procedure



Physician[1]

CPT® code[2]	Description	Payment in office	Payment in facility	Relative value units (RVUs) Physician work RVUs
Bone tumor ablation and vertebroplasty				
20982	Ablation therapy for reduction or eradication of one or more bone tumors (e.g., metastasis), including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency	$3,485	$322	6.84
(+) 22510	Percutaneous vertebroplasty (bone biopsy included when performed), one vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic	$4,367	$544	11.12
(+) 22512	Two-level vertebroplasty	$5,107	$725	15.02
(+) 22512	Three-level vertebroplasty	$5,847	$907	18.92
20982	Ablation therapy for reduction or eradication of one or more bone tumors (e.g., metastasis), including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency	$3,485	$322	6.84
(+) 22511	Percutaneous vertebroplasty (bone biopsy included when performed), one vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral	$4,367	$522	10.57
(+) 22512	Two-level vertebroplasty	$5,113	$704	14.47
(+) 22512	Three-level vertebroplasty	$5,853	$885	18.37

Multiple procedures

Physician fees are subject to multiple procedure reduction when the above CPT code combinations are billed together. The higher-valued code will be reimbursed by Medicare at 100% of the rate, and subsequent codes will be reimbursed at 50%. Modifier -51 reporting requirements varies by MAC and payer. Commercial payers typically apply a similar multiple procedure adjustment. Providers should verify payment provisions within individual commercial payer contracts.

Physician[1]

CPT® code[2]	Description	Payment in office	Payment in facility	Relative value units (RVUs) Physician work RVUs
Bone tumor ablation and vertebral augmentation				
20982	Ablation therapy for reduction or eradication of one or more bone tumors (e.g., metastasis), including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency	$3,485	$322	6.84
(+) 22513	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., vertebral augmentation), one vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic	$7,458	$614	11.85
(+) 22515	Two-level vertebral augmentation	$10,527	$803	15.75
(+) 22515	Three-level vertebral augmentation	$13,507	$992	19.65
20982	Ablation therapy for reduction or eradication of one or more bone tumors (e.g., metastasis), including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency	$3,485	$322	6.84
(+) 22514	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., vertebral augmentation), one vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar	$7,553	$585	11.21
(+) 22515	Two-level vertebral augmentation	$10,532	$774	15.11
(+) 22515	Three-level vertebral augmentation	$13,512	$962	19.01

Multiple procedures

Physician fees are subject to multiple procedure reduction when the above CPT code combinations are billed together. The higher-valued code will be reimbursed by Medicare at 100% of the rate, and subsequent codes will be reimbursed at 50%. Modifier -51 reporting requirements varies by MAC and payer. Commercial payers typically apply a similar multiple procedure adjustment. Providers should verify payment provisions within individual commercial payer contracts.

Ambulatory surgery center (ASC)[3]

CPT® code[2]	Description	Multiple procedure discounting	ASC payment
Bone tumor ablation and vertebroplasty			
20982	Ablation therapy for reduction or eradication of one or more bone tumors (e.g., metastasis), including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency	Y	$9,256
(+) 22510	Percutaneous vertebroplasty (bone biopsy included when performed), one vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic	Y	$10,078
(+) C7504	Percutaneous vertebroplasties (bone biopsies included when performed), first cervicothoracic and any additional cervicothoracic or lumbosacral vertebral bodies, unilateral or bilateral injection, inclusive of all imaging guidance (Code pair 22510 + 22512)	Y	$11,104
20982	Ablation therapy for reduction or eradication of one or more bone tumors (e.g., metastasis), including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency	Y	$9,256
(+) 22511	Percutaneous vertebroplasty (bone biopsy included when performed), one vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral	Y	$10,078
(+) C7505	Percutaneous vertebroplasties (bone biopsies included when performed), first lumbosacral and any additional cervicothoracic or lumbosacral vertebral bodies, unilateral or bilateral injection, inclusive of all imaging guidance (Code pair 22511 + 22512)	Y	$11,104

Ambulatory surgery center (ASC)[3]

CPT® code[2]	Description	Multiple procedure discounting	ASC payment
Bone tumor ablation and vertebral augmentation			
20982	Ablation therapy for reduction or eradication of one or more bone tumors (e.g., metastasis), including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency	Y	$9,256
(+) 22513	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., vertebral augmentation), one vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic	Y	$11,104
(+) C7507	Percutaneous vertebral augmentations, first thoracic and any additional thoracic or lumbar vertebral bodies, including cavity creations (fracture reductions and bone biopsies included when performed) using mechanical device (e.g., kyphoplasty), unilateral or bilateral cannulations, inclusive of all imaging guidance (Code pair 22513 + 22515)	Y	$12,658
20982	Ablation therapy for reduction or eradication of one or more bone tumors (e.g., metastasis), including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency	Y	$9,256
(+) 22514	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., vertebral augmentation), one vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar	Y	$11,104
(+) C7508	Percutaneous vertebral augmentations, first lumbar and any additional thoracic or lumbar vertebral bodies, including cavity creations (fracture reductions and bone biopsies included when performed) using mechanical device (e.g., kyphoplasty), unilateral or bilateral cannulations, inclusive of all imaging guidance (Code pair 22514 + 22515)	Y	$12,658

Hospital outpatient[3]

CPT® code[2]	Description	Ambulatory payment classification (APC)	APC payment
Bone tumor ablation and vertebroplasty			
20982	Ablation therapy for reduction or eradication of one or more bone tumors (e.g., metastasis), including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency	5116	$17,914
(+) 22510	Percutaneous vertebroplasty (bone biopsy included when performed), one vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic	5116	$17,914
(+) 22512	Two-level vertebroplasty	5116	$17,914
(+) 22512	Three-level vertebroplasty	5116	$17,914
20982	Ablation therapy for reduction or eradication of one or more bone tumors (e.g., metastasis), including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency	5116	$17,914
(+) 22511	Percutaneous vertebroplasty (bone biopsy included when performed), one vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral	5116	$17,914
(+) 22512	Two-level vertebroplasty	5116	$17,914
(+) 22512	Three-level vertebroplasty	5116	$17,914

Note: Bone tumor ablation, when combined with vertebroplasty or vertebral augmentation, pays at the same APC, regardless of number of levels treated.

Hospital outpatient[3]

CPT® code[2]	Description	Ambulatory payment classification (APC)	APC payment
Bone tumor ablation and vertebral augmentation			
20982	Ablation therapy for reduction or eradication of one or more bone tumors (e.g., metastasis), including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency	5116	$17,914
(+) 22513	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., vertebral augmentation), one vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic	5116	$17,914
(+) 22515	Two-level vertebral augmentation	5116	$17,914
(+) 22515	Three-level vertebral augmentation	5116	$17,914
20982	Ablation therapy for reduction or eradication of one or more bone tumors (e.g., metastasis), including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency	5116	$17,914
(+) 22514	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., vertebral augmentation), one vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar	5116	$17,914
(+) 22515	Two-level vertebral augmentation	5116	$17,914
(+) 22515	Three-level vertebral augmentation	5116	$17,914

Note: Bone tumor ablation, when combined with vertebroplasty or vertebral augmentation, pays at the same APC, regardless of number of levels treated.

Notes:

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

•Bone tumor ablation, when combined with vertebroplasty or vertebral augmentation, pays at the same APC in the hospital outpatient, regardless of number of levels treated.

Multiple procedures

Physician fees are subject to multiple procedure reduction when the above CPT code combinations are billed together. The higher-valued code will be reimbursed by Medicare at 100% of the rate, and subsequent codes will be reimbursed at 50%. Modifier -51 reporting requirements varies by MAC and payer. Commercial payers typically apply a similar multiple procedure adjustment. Providers should verify payment provisions within individual commercial payer contracts.

References

1. 2026 CMS PFS Final Rule, Addendum B (published November 3, 2025). Medicare national average physician payment rates listed in this document are based on the 11/3/25 release of the relative value file and non-qualifying APM conversion factor of 33.4009. https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1832-f.
2. Current Procedural Terminology 2025, American Medical Association. Chicago, IL 2025. CPT is a registered trademark of the American Medical Association. Current Procedural Terminology (CPT®) is copyright 2025 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
3. 2026 CMS OPPS/ASC Final Rule, Addendum AA, B and J (published November 21, 2025). https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1834-fc.
4. Healthcare Common Procedure Coding System (HCPCS) Level II codes are maintained by the Centers for Medicare and Medicaid Services.

Indications for use

For Stryker products, refer to Indications for Use section within the Instructions for Use (IFU).

Questions? Contact IVS reimbursement support

954 302 4591 | **IVS-reimbursement@stryker.com**

Interventional Spine

Bone cement: Serious adverse events, some with fatal outcome, associated with the use of bone cements for vertebroplasty, kyphoplasty and sacroplasty include myocardial infarction, cardiac arrest, cerebrovascular accident, pulmonary embolism and cardiac embolism. Although it is rare, some adverse events have been known to occur beyond a year or more post-operatively. Additional risks exist with the use of bone cement. Please see the IFU for a complete list of potential risks.

This document is intended solely for the use of healthcare professionals. Reimbursement, coding, coverage and payment information is provided for general information only and is not intended to provide coverage, coding, payment, medical treatment or legal advice. Stryker does not warrant, promise, guarantee or make any statement that the codes supplied in this guide are appropriate for any individual patient or that the use of this information will result in coverage or payment for treatment using any Stryker products or that any payment received will reimburse a provider's costs. The information is not intended to guarantee or increase payment by any payor. Laws, regulations and policies concerning reimbursement are complex, subject to change and updated regularly.

Stryker does not assume any responsibility for coding decisions, nor does it recommend codes for specific patients' procedures. The provider is solely responsible for reporting the codes that accurately describe the services furnished to a particular patient as well as the patient's medical condition. It is the provider's responsibility to determine and document that the services provided are medically necessary and that the site of service is appropriate. It is the healthcare provider's responsibility to report the patient diagnosis, the procedures performed and the products used, consistent with the specific payer's guidelines.

Stryker defers to specialty society guidelines, payer policies and guidelines, Medicare and the AMA regarding the submission of claims and the appropriate coding for procedures and products.

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 payment rates. Payment to individual providers will vary based on a number of variables, including geographic location.

This information in this document is accurate as of February 2026, and all coding and reimbursement information is subject to change without notice. Please contact your Medicare Administrative Contractor or Private Payer for billing, payment and coverage information.

Stryker Instruments
1941 Stryker Way
Portage, MI 49002

stryker.com