2026 reimbursement guide

Percutaneous vertebral augmentation

Physician[1]

CPT® code[2]	Description	Payment in office	Payment in facility	Relative value units (RVUs) Non-facility RVUs	Relative value units (RVUs) Facility RVUs	Global period
Percutaneous vertebral augmentation						
22513	**Thoracic** Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), one vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic	$5,805	$453	173.80	13.57	10
22514	**Lumbar** Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), one vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar	$5,810	$424	173.95	12.70	10
+22515	**Each additional** Each additional thoracic or lumbar vertebral body (list separately in addition to code for primary procedure 22513 + 22515 or 22514 + 22515)	$2,980	$189	89.21	5.65	ZZZ
Percutaneous sacral augmentation (sacroplasty)						
0200T	**One or more needles** Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used, one or more needles, includes imaging guidance and bone biopsy, when performed	N/A	CP	N/A	N/A	XXX
0201T	**Two or more needles** Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, two or more needles, includes imaging guidance and bone biopsy, when performed					

ZZZ: Add-on codes that must be billed with another service. The Medicare PFS payment doesn't include post-operative work ZZZ codes.
XXX: The global concept does not apply to the code.
CP: Carrier-priced

ICD-10 diagnosis codes[3]

M80.08 Age-related osteoporosis with current pathological fracture, vertebra(e):
- **M80.08XA–** initial encounter for fracture;
- **M80.08XS–** sequela

M80.88 Other osteoporosis with current pathological fracture, vertebra(e):
- **M80.88XA–** initial encounter for fracture;
- **M80.88XS–** sequela

M84.58 Pathological fracture in neoplastic disease, other specified site (vertebra):
- **M84.58XA–** initial encounter for fracture;
- **M84.58XS–** sequela

C41.2* Malignant neoplasm of vertebral column
C79.51* Secondary malignant neoplasm of bone
C79.52* Secondary malignant neoplasm of bone marrow
C90.00* Multiple myeloma not having achieved remission
C90.01* Multiple myeloma in remission
C90.02* Multiple myeloma in relapse

*Dual diagnosis is required.

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Ambulatory surgery center (ASC)[4]

CPT® code[2]	Description	Payment indicator	Multiple procedure discounting	ASC payment
Percutaneous vertebral augmentation				
22513	**Thoracic** Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), one vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic	G2	Y	$3,696
22514	**Lumbar** Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), one vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar	G2	Y	$3,696
+22515	**Each additional** Each additional thoracic or lumbar vertebral body (list separately in addition to code for primary procedure 22513 + 22515 or 22514 + 22515)	N1	N/A	N/A
C7507	**Procedural code pair representing codes listed** 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 (eg, kyphoplasty), unilateral or bilateral cannulations, inclusive of all imaging guidance (Code pair 22513 + 22515)	G2	Y	$6,804
C7508	**Procedural code pair representing codes listed** 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 (eg, kyphoplasty), unilateral or bilateral cannulations, inclusive of all imaging guidance (Code pair 22514 + 22515)	G2	Y	$6,804
Percutaneous sacral augmentation (sacroplasty)				
0200T	**One or more needles** Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used, one or more needles, includes imaging guidance and bone biopsy, when performed	J8	Y	$4,720
0201T	**Two or more needles** Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, two or more needles, includes imaging guidance and bone biopsy, when performed	G2	Y	$3,696

G2: Non-office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight
N1: Packaged service/item; no separate payment made
J8: Device-intensive procedure; paid at adjusted rate

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C90.00* Multiple myeloma not having achieved remission
C90.01* Multiple myeloma in remission
C90.02* Multiple myeloma in relapse

*Dual diagnosis is required.

Hospital outpatient[4]

CPT® code[2]	Description	Status indicator	Ambulatory payment classification (APC)	APC payment
Percutaneous vertebral augmentation				
22513	**Thoracic** Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), one vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic	J1	5114	$7,413
22514	**Lumbar** Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), one vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar	J1	5114	$7,413
+22515	**Each additional** Each additional thoracic or lumbar vertebral body (list separately in addition to code for primary procedure 22513 + 22515 or 22514 + 22515)	N	5115	$13,117
Percutaneous sacral augmentation (sacroplasty)				
0200T	**One or more needles** Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used, one or more needles, includes imaging guidance and bone biopsy, when performed	J1	5114	$7,413
0201T	**Two or more needles** Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, two or more needles, includes imaging guidance and bone biopsy, when performed	J1	5114	$7,413

J1: Hospital Part B services paid through a comprehensive APC
N: Items and services packaged into APC rates
Note: When CPT code 22515 is reported in the hospital outpatient department with the primary procedure code 22513 or 22514, the complexity adjustment results in an adjusted APC assignment.

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HCPCS II device codes[5]

SpineJack system C1062
Intravertebral body fracture augmentation with implant (e.g., metal, polymer)

Cement C1713
Anchor/screw for opposing bone-to-bone (implantable)

Balloons C1889
Implantable/insertable device, not otherwise classified device

Hospital inpatient[6]

MS-DRGs inpatient reimbursement[6]

Code	Description	Payment
MS-DRGs		
515	Other musculoskeletal system and connective tissue procedures with MCC* OR	$23,190
516	Other musculoskeletal system and connective tissue procedures with CC** OR	$15,122
517	Other musculoskeletal system and connective tissue procedures without CC/MCC*** OR	$11,182

*Major complication or comorbidity
**Complication or comorbidity
***Complication or comorbidity/major complication or comorbidity

ICD-10-PCS procedure codes[7]

Hospitals use ICD-10-PCS procedure codes for inpatient services. The following ICD-10-PCS X codes are appropriate to report with the Stryker SpineJack system.

XNU0356	Supplement Lumbar Vertebra with Mechanically Expandable (Paired) Synthetic Substitute, Percutaneous Approach, New Technology Group 6
XNU4356	Supplement Thoracic Vertebra with Mechanically Expandable (Paired) Synthetic Substitute, Percutaneous Approach, New Technology Group 6

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Notes:
- "N/A" indicates that this concept does not apply, or that Medicare has not developed fee schedules in those settings of care.
- When CPT code 22515 is reported in the hospital outpatient department with the primary procedure code 22513 or 22514, the complexity adjustment results in an adjusted APC assignment.

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. International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) (available on CMS.gov). Codes shown are examples. Please check your local LCD or with the specific payer for diagnosis codes that support medical necessity.
4. 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.
5. Healthcare Common Procedure Coding System (HCPCS) Level II codes are maintained by the Centers for Medicare and Medicaid Services.
6. FY 2026 IPPS Final Rule (available on CMS.gov).
7. Centers for Medicare & Medicaid Services. International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS) (available on CMS.gov).

Indications for use

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

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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 January 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.

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