2026 reimbursement guide

Percutaneous vertebroplasty

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 vertebroplasty						
22510	**Cervicothoracic** Percutaneous vertebroplasty (bone biopsy included when performed), one vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic	$1,764	$383	52.82	11.47	10
22511	**Lumbosacral** Percutaneous vertebroplasty (bone biopsy included when performed), one vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral	$1,775	$361	53.13	10.82	10
+22512	**Each additional vertebral body** Each additional cervicothoracic or lumbosacral vertebral body (list separately in addition to code for primary procedure 22510 + 22512 or 22511 + 22512)	$740	$181	22.16	5.43	ZZZ

ZZZ: Add-on codes that must be billed with another service. The Medicare PFS payment doesn't include post-operative work ZZZ codes.

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 vertebroplasty				
22510	**Cervicothoracic** Percutaneous vertebroplasty (bone biopsy included when performed), one vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic	G2	Y	$1,645
22511	**Lumbosacral** Percutaneous vertebroplasty (bone biopsy included when performed), one vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral	G2	Y	$1,645
+22512	**Each additional vertebral body** Each additional cervicothoracic or lumbosacral vertebral body (list separately in addition to code for primary procedure 22510 + 22512 or 22511 + 22512)	N1	N/A	N/A
C7504	**Procedural code pair representing codes listed** 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)	G2	Y	$3,696
C7505	**Procedural code pair representing codes listed** 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)	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.

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.

Hospital outpatient[4]

CPT® code[2]	Description	Status indicator	Ambulatory payment classification (APC)	APC payment
Percutaneous vertebroplasty				
22510	**Cervicothoracic** Percutaneous vertebroplasty (bone biopsy included when performed), one vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic	J1	5113	$3,343
22511	**Lumbosacral** Percutaneous vertebroplasty (bone biopsy included when performed), one vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral	J1	5113	$3,343
+22512	**Each additional vertebral body** Each additional cervicothoracic or lumbosacral vertebral body (list separately in addition to code for primary procedure 22510 + 22512 or 22511 + 22512)	N	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 22512 is reported in the hospital outpatient department with the primary procedure code 22510 or 22511, the complexity adjustment results in an adjusted APC assignment.

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.

HCPCS II device codes[5]

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

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 OR procedures with MCC*	$23,190
516	Other musculoskeletal system and connective tissue OR procedures with CC**	$15,122
517	Other musculoskeletal system and connective tissue OR procedures without CC/MCC***	$11,182

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

Notes:

- "N/A" indicates that this concept does not apply, or that Medicare has not developed fee schedules in those settings of care.
- For the purposes of reporting 22510, 22511, 22512, "vertebroplasty" is the process of injecting a material (cement) into the vertebral body (without creating a cavity) to reinforce the structure of the body using image guidance.
- When CPT code 22512 is reported in the hospital outpatient department with the primary procedure code 22510 or 22511, 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).

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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.

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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 December 2, 2025, 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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