Medtronic

Balloon Kyphoplasty

Commonly Billed Codes
2022

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ICD-10-CM[1] Diagnosis Codes

Diagnosis codes are used by both physicians and hospitals to document the indication for the procedure.

Balloon kyphoplasty is performed for pathological fractures of the vertebrae due to osteoporosis and other underlying conditions as labeled. Medicare contractors have established Local Coverage Determinations (LCDs) and associated Local Coverage Articles (LCAs) which list medical indications for coverage and the ICD-10-CM diagnosis codes supporting medical necessity for Kyphon balloon kyphoplasty procedures. LCDs and LCAs are available on the CMS website at https://www.cms.gov/medicare-coverage-database/new-search/search.aspx . Other payers also have medical policies which list ICD-10-CM diagnosis codes supporting medical necessity.

The diagnosis codes shown below are those commonly found on Medicare LCDs and LCAs. For Medicare, the first set of diagnosis codes for vertebral fractures due to osteoporosis are listed for all MACs and are generally covered. The second set of diagnosis codes for vertebral fractures due to malignancy are listed for only some MACs and have limited coverage. Providers should check LCDs and LCAs for their specific Medicare contactor as well as medical policies for other payers who may also accept additional diagnosis codes.

Note: While balloon kyphoplasty is typically covered in the thoracic and lumbar spine for listed diagnosis codes, sacroplasty is typically not covered at this time regardless of the diagnosis. Again, providers should review LCDs and LCAs for their specific Medicare contractor as well as local commercial policies, or contact the payer directly to determine if sacroplasty is covered.

Vertebral Fractures due to Osteoporosis	
ICD-10-CM Code	**DESCRIPTION**
M80.08XA	Age-related osteoporosis with current pathological fracture, vertebra(e), initial encounter[2,3,4]
M80.08XS	Age-related osteoporosis with current pathological fracture, vertebra(e), sequela
M80.88XA	Other osteoporosis with current pathological fracture, vertebra(e), initial encounter[2,3,4]
M80.88XS	Other osteoporosis with current pathological fracture, vertebra(e), sequela

Vertebral Fractures due to Osteoporosis	
Note: For Medicare, according to LCDs, pathological fracture codes M84.58XA or M84.58XS must accompany the other malignancy codes.[5]	
ICD-10-CM Code	**DESCRIPTION**
M84.58XA	Pathological fracture in neoplastic disease, other specified site, initial encounter[2,6]
M84.58XS	Pathological fracture in neoplastic disease, other specified site, sequela
C41.2	Malignant neoplasm of vertebral column
C79.51	Secondary malignant neoplasm of bone
C90.00	Multiple myeloma not having achieved remission
C90.02	Multiple myeloma in relapse

1. Centers for Disease Control and Prevention, National Center for Health Statistics. International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM). http://www.cdc.gov/nchs/icd/icd10cm.htm. Updated October 1, 2021.
2. Seventh character A-initial encounter continues to be assigned as long as the patient is receiving active treatment for the fracture. ICD-10-CM Official Guidelines for Coding and Reporting (Diagnoses) FY 2022, I.C.13.c.
3. Per ICD-10-CM inclusion notes, age-related osteoporosis includes postmenopausal osteoporosis. Other osteoporosis includes drug-induced, disuse, post-surgical, and post-traumatic. Unspecified osteoporosis defaults to age-related.
4. A code from category M80, rather than a traumatic fracture code, should be used for any patient with known osteoporosis who suffers a fracture, even if the patient had a minor fall or trauma, if that fall or trauma would not usually break a normal, healthy bone. ICD-10-CM Official Guidelines for Coding and Reporting (Diagnoses) FY 2022, I.C.13.d.2.
5. When the encounter is specifically for vertebroplasty, the pathological fracture code is sequenced first followed by the code for the specific malignancy. ICD-10-CM Official Guidelines for Coding and Reporting (Diagnoses) FY 2022, I.C.2.L.6
6. I n code M84.58XA, "other specified site" includes vertebrae per ICD-10-CM inclusion notes.

HCPCS C-Codes[1] for Devices

Medicare provides C-codes to identify medical devices used by hospitals in outpatient procedures.[2] C-codes for the device are assigned in addition to the CPT codes for the procedures in which the device is used. Medicare does not require these specific C-codes to be billed and does not provide additional payment for them. However, their use in billing enables maintenance of accurate databases from which future payment rates are derived.

Some commercial payers recognize C-codes and may also allow additional payment. Hospitals should check their specific commercial payer contracts for the payment provisions for each payer.

Device	HCPCS Code	DESCRIPTION
Cement	C1713	Anchor/screw for apposing bone-to-bone or soft tissue-to-bone (implantable)[3]

1. Healthcare Common Procedure Coding System (HCPCS) Level II codes C-codes are maintained by the Centers for Medicare and Medicaid Services. https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update. Accessed January 3, 2022.
2. HCPCS C-codes are designed for hospital outpatient billing only, although some hospitals may choose to assign C-codes with inpatient encounters strictly for internal tracking purposes. In general, although ASCs should bill all charges incurred, ASC should not bill C-codes separately. Medicare Claims Processing Manual, Chapter 14—Ambulatory Surgical Centers, Section 40. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c14.pdf. Accessed January 3, 2022.
3. Code C1713 may be assigned to report the cement used in cementoplasty. Notwithstanding the code definition, C1713 also applies to "synthetic bone substitutes that may be used to fill bony void or gaps (ie, bone substitute implanted into a bony defect created from trauma or surgery)". Medicare Claims Processing Manual, Chapter 4, Section 60.4.3. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf . In particular, note that code C1734, Orthopedic/device/drug matrix for apposing bone-to-bone or soft tissue-to bone (implantable), is reserved for a type of augmented bone graft used in ankle fusion procedures and is not applicable to bone cement.

PHYSICIAN CODING AND PAYMENT JANUARY 1, 2022 - DECEMBER 31, 2022
CPT® PROCEDURE CODES

Physicians use CPT[1] codes for all services. Under Medicare's Resource-Based Relative Value Scale (RBRVS) methodology for physician payment, each CPT code is assigned a point value, known as the relative value unit (RVU), which is then converted to a flat payment amount.

		MEDICARE RVU[2]		MEDICARE NATIONAL AVERAGE[3]		Multiple Procedure Discount[2]
CPT CODE	DESCRIPTION	PHYSICIAN OFFICE	FACILITY	PHYSICIAN OFFICE	FACILITY	
22513	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic	179.55	15.01	$6,214	$519	Y
22514	- lumbar	178.67	13.97	$6,183	$483	Y
+22515	- each additional thoracic or lumbar vertebral body[4]	92.45	6.42	$3,199	$222	N
0200T	Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used, 1 or more needles, includes imaging guidance and bone biopsy, when performed[5]	–	Contractor priced[6]	–	Contractor priced[6]	–
0201T	Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, 2 or more needles, includes imaging guidance and bone biopsy, when performed[5]	–	Contractor priced[6]	–	Contractor priced[6]	–

MULTIPLE PROCEDURES:
The kyphoplasty codes are subject to multiple procedure reduction when billed together with other procedure codes during the same encounter. Medicare pays 100% of the rate for the higher-valued code. Medicare then pays the lower-valued code, which should be submitted with multiple procedure modifier -51, at 50% of the rate. As an exception, add-on code +22515 is not subject to discounting and is always paid at 100% of the rate.

COMMERCIAL PAYERS:
Many non-Medicare payers use a similar relative value system to determine physician payment, although the values themselves may be different. Commercial payers typically apply a similar multiple procedure discount when more than one procedure code is billed. Note that some commercial payers do not sort the codes by value and instead pay the first-listed code at 100% of the rate and reduce the second-listed code by the contracted percent. Other payers may use alternate payment methodologies. Physicians should check their specific commercial payer contracts for the payment provisions for each payer.

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2. Centers for Medicare & Medicaid Services. Medicare Program; CY2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies Final Rule; 86 Fed. Reg. 64996-66031 https://www.govinfo.gov/content/pkg/FR-2021-11-19/pdf/2021-23972.pdf . Published November 19, 2021. The total RVU as shown here is the sum of three components: physician work RVU, practice expense RVU, and malpractice RVU. The RVUs shown are for the physician's services and payment is made to the physician. However, there are different RVUs and payments depending on the setting in which the physician rendered the service. "Facility" includes physician services rendered in hospitals and ASCs. Physician RVUs and payments are generally lower in the "Facility" setting because the facility is incurring the cost of some of the supplies and other materials. Physician RVUs and payments are generally higher in the "Physician Office" setting because the physician incurs all costs there.
3. Medicare national average payment is determined by multiplying the sum of the three RVUs by the conversion factor. The conversion factor for conversion factor for CY 2022 is $34.6062 per 86 Fed. Reg. 65619 as amended by the Protecting Medicare and American Farmers from Sequester Cuts Act, signed December 10, 2021 See also the current 2022 release of the PFS Relative Value File at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html. Final payment to the physician is adjusted by the Geographic Practice Cost Indices (GPCI). Also note that any applicable coinsurance, deductible, and other amounts that are patient obligations are included in the payment amount shown.
4. The provider may report only one primary procedure code plus the add-on code +22515 for each additional level regardless of whether the additional level(s) are contiguous or not, per National Correct Coding Initiative (NCCI) Policy Manual 1/1/2022, Chapter IV, F.4.
5. Codes 0200T and 0201T are used for kyphoplasty of the sacrum (sacroplasty). Code 0200T is defined as "unilateral" and represents kyphoplasty of either the right or left side of the sacrum, regardless of the number of sacral levels. Code 0201T is defined as "bilateral" and represents kyphoplasty of both the right and left side of the sacrum, regardless of the number of sacral levels. See also CPT Assistant April 2015, p. 8.
6. For Medicare, this is a contractor-priced code. Contractors establish the RVUs and the payment amount, usually on an individual basis after review of the procedure report.

CPT® PROCEDURE CODES

Hospitals use CPT[1] codes for outpatient services. Under Medicare's APC methodology for hospital outpatient payment, each CPT code is assigned to one of approximately 820 ambulatory payment classes. Each APC has a relative weight that is then converted to a flat payment amount. Multiple APCs can sometimes be assigned for each encounter, depending on the number of procedures coded and whether any of the procedure codes map to a Comprehensive APC.

For 2022, there are 69 APCs which are designated as Comprehensive APCs (C-APCs). Each CPT procedure code assigned to one of these C-APCs is considered a primary service, and all other procedures and services coded on the bill are considered adjunctive to delivery of the primary service. This results in a single APC payment and a single beneficiary co-payment for the entire outpatient encounter, based solely on the primary service. Separate payment is not made for any of the other adjunctive services. Instead, the payment level for the C-APC is calculated to include the costs of the other adjunctive services, which are packaged into the payment for the primary service. C-APCs are identified by status indicator J1.

When more than one primary service is coded for the same outpatient encounter, the codes are ranked according to a fixed hierarchy. The C-APC is then assigned according to the highest ranked code. In some special circumstances, the combination of two primary services leads to a "complexity adjustment" in which the entire encounter is re-mapped to another higher-level APC. Kyphoplasty of the thoracic and lumbar spine qualifies for a complexity adjustment when additional levels are treated during the same outpatient encounter.

CPT CODE	DESCRIPTION	APC[2]	STATUS INDICATOR[3]	RELATIVE WEIGHT[2]	MEDICARE NATIONAL AVG[4]
22513	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic	5114, Level 4 Musculoskeletal Procedures	J1	75.9952	$6,397
22514	- lumbar	5114, Level 4 Musculoskeletal Procedures	J1	75.9952	$6,397
22513 plus +22515	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic - each additional thoracic or lumbar vertebral body[5]	5115, Level 5 Musculoskeletal Procedures	J1	149.6049	$12,593
22514 plus +22515	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar - each additional thoracic or lumbar vertebral body[5]	5115, Level 5 Musculoskeletal Procedures	J1	149.6049	$12,593
0200T	Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used, 1 or more needles, includes imaging guidance and bone biopsy, when performed[6]	5114, Level 4 Musculoskeletal Procedures	J1	75.9952	$6,397
0201T	Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, 2 or more needles, includes imaging guidance and bone biopsy, when performed[6]	5114, Level 4 Musculoskeletal Procedures	J1	75.9952	$6,397

COMMERCIAL PAYERS:

Many non-Medicare payers use an APC methodology or similar type of fee schedule to determine hospital payment for outpatient services, although the specific payment amounts and other policies may differ. Other payers may use a percentage of charges or another contracted methodology. Hospitals should check their specific commercial payer contracts for the payment provisions for each payer.

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2. Centers for Medicare & Medicaid Services. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems... Final Rule. 86 Fed Reg 63458-63998. https://www.govinfo.gov/content/pkg/FR-2021-11-16/pdf/2021-24011.pdf . Published November 16, 2021.
3. Status Indicator (SI) shows how a code is handled for payment purposes: J1 = paid under comprehensive APC, single payment based on primary service without separate payment for other adjunctive services.
4. Medicare national average payment is determined by multiplying the APC weight by the conversion factor. The conversion factor for 2022 is $84.117. The conversion factor of $84.117 assumes that hospitals meet reporting requirements of the Hospital Outpatient Quality Reporting Program. Centers for Medicare & Medicaid Services. Medicare Program: Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment Systems... Final Rule. 86 Fed Reg 63500. https://www.govinfo.gov/content/pkg/FR-2021-11-16/pdf/2021-24011.pdf . Published November 16, 2021. Payment is adjusted by the wage index for each hospital's specific geographic locality, so payment will vary from the national average Medicare payment levels displayed. Also note that any applicable coinsurance, deductible, and other amounts that are patient obligations are included in the national average payment amount shown.
5. The provider may report only one primary procedure code plus the add-on code +22515 for each additional level regardless of whether the additional level(s) are contiguous or not, per National Correct Coding Initiative (NCCI) Policy Manual 1/1/2022, Chapter IV, F.4.
6. Codes 0200T and 0201T are used for kyphoplasty of the sacrum (sacroplasty). Code 0200T is defined as "unilateral" and represents kyphoplasty of either the right or left side of the sacrum, regardless of the number of sacral levels. Code 0201T is defined as "bilateral" and represents kyphoplasty of both the right and left side of the sacrum, regardless of the number of sacral levels. See also CPT Assistant April 2015, p. 8.

ICD-10-PCS[1] Procedure Codes

Hospitals use ICD-10-PCS procedure codes for inpatient services.

KYPHOPLASTY

ICD-10-PCS requires purposeful creation of a cavity and also recognizes cavity creation as an attempt to at least partially restore vertebral height by intentionally repositioning bone. For this reason, kyphoplasty requires two codes in ICD-10-PCS and the codes must be used together to capture the entire procedure. The root operation for the first code is S-Reposition which represents restoration of height and spinal alignment. The root operation for the second code is U-Supplement which represents the cement injection with device value J-Synthetic Substitute used for the cement. In effect, kyphoplasty is coded as vertebral height restoration with cement injection.[2,3]

ICD-10-PCS Code	Code Description
0PS43ZZ	Reposition thoracic vertebra, percutaneous approach
plus	
0PU43JZ	Supplement thoracic vertebra with synthetic substitute, percutaneous approach
0QS03ZZ	Reposition lumbar vertebra, percutaneous approach
plus	
0QU03JZ	Supplement lumbar vertebra with synthetic substitute, percutaneous approach
0QS13ZZ	Reposition sacrum, percutaneous approach
plus	
0QU13JZ	Supplement sacrum with synthetic substitute, percutaneous approach

BIOPSY OF VERTEBRA

Vertebral biopsy is sometimes performed together with kyphoplasty and is coded separately in ICD-10-PCS.[2] Root operation B-Excision with qualifier X-Diagnostic are used for biopsy.

ICD-10-PCS Code	Code Description
0PB43ZX	Excision of thoracic vertebra, percutaneous approach, diagnostic
0QB03ZX	Excision of lumbar vertebra, percutaneous approach, diagnostic
0QB13ZX	Excision of sacrum, percutaneous approach, diagnostic

1. Centers for Medicare & Medicaid Services. International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS). https://www.cms.gov/medicare/icd-10/2022-icd-10-pcs . Updated October 1, 2021.
2. ICD-10-CM and ICD-10-PCS Coding Handbook 2020, Central Office on ICD-10-CM and ICD-10-PCS of the American Hospital Association, Chapter 23, Vertebroplasty and Kyphoplasty, p.308-309.
3. Coding Clinic, 2nd Q 2014, p.12.

Diagnosis-Related Groups (DRGs)

Under Medicare's MS-DRG methodology for hospital inpatient payment, each inpatient stay is assigned to one of about 765 diagnosis-related groups, based on the ICD-10-CM codes assigned to the diagnoses and ICD-10-PCS codes assigned to the procedures. Each MS-DRG has a relative weight that is then converted to a flat payment amount. Only one MS-DRG is assigned for each inpatient stay, regardless of the number of procedures performed.

Note: The MS-DRGs shown are those typically assigned with the diagnosis codes commonly found on Medicare LCDs and LCAs. Other DRGs may be available for payers that accept additional diagnosis codes.

KYPHOPLASTY FOR PATHOLOGICAL FRACTURES DUE TO OSTEOPOROSIS OR MALIGNANCY

When patients are admitted for pathological fracture due to osteoporosis or malignancy and kyphoplasty procedures are performed, without any additional procedures during the same inpatient admission, the following DRGs are typically assigned.

MS-DRG[1]	MS-DRG TITLE[2]	RELATIVE WEIGHT[2]	MEDICARE NATIONAL AVG[3]
515	Other Musculoskeletal System and Connective Tissue O.R. Procedures W MCC	3.1406	$20,710
516	Other Musculoskeletal System and Connective Tissue O.R. Procedures W CC	1.9628	$12,943
517	Other Musculoskeletal System and Connective Tissue O.R. Procedures WO CC/MCC	1.3982	$9,220

KYPHOPLASTY WITH VERTEBRAL BIOPSY FOR PATHOLOGICAL FRACTURES DUE TO OSTEOPOROSIS OR MALIGNANCY

When patients are admitted for pathological fracture due to osteoporosis or malignancy and a vertebral biopsy is performed with the kyphoplasty, the biopsy procedure code takes precedence and the following DRGs are typically assigned.

MS-DRG[1]	MS-DRG TITLE[2]	RELATIVE WEIGHT[2]	MEDICARE NATIONAL AVG[3]
477	Biopsies of Musculoskeletal System and Connective Tissue W MCC	3.3589	$22,149
478	Biopsies of Musculoskeletal System and Connective Tissue W CC	2.3584	$15,552
479	Biopsies of Musculoskeletal System and Connective Tissue WO CC/MCC	1.8095	$11,932

COMMERCIAL PAYERS:

Many non-Medicare payers use a similar DRG or per case system to determine hospital payment for inpatient encounters, although the specific DRGs and payment amounts may be different. Others pay the hospital on a contractual basis (eg, per diem rate) that has been negotiated between the hospital and the payer. Hospitals should check their specific commercial payer contracts for the payment provisions for each payer.

1. Centers for Medicare & Medicaid Services. Medicare Program: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Policy Changes and FY2022 Rates Final Rule 86 Fed. Reg. 44774-45615. https://www.govinfo.gov/content/pkg/FR-2021-08-13/pdf/2021-16519.pdf . Published August 13, 2021. Correction Notice 86 Fed. Reg. 58019-58039. https://www.govinfo.gov/content/pkg/FR-2021-10-20/pdf/2021-22724.pdf . Published October 20, 2021.
2. W MCC in MS-DRG titles refers to secondary diagnosis codes that are designated as major complications or comorbidities. MS-DRGs W MCC have at least one major secondary complication or comorbidity. Similarly, W CC in MS-DRG titles refers to secondary diagnosis codes designated as other (non-major) complications or comorbidities, and MS-DRGs W CC have at least one other (non-major) secondary complication or comorbidity. MS-DRGs W/O CC/MCC have no secondary diagnoses that are designated as complications or comorbidities, major or otherwise. Note that some secondary diagnoses are only designated as CCs or MCCs when the conditions were present on admission, and do not count as CCs or MCCs when the conditions are acquired in the hospital during the stay.
3. Payment is based on the average standardized operating amount ($6,121.65) plus the capital standard amount ($472.59). Centers for Medicare & Medicaid Services. Medicare Program: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Policy Changes and FY2022 Rates. Final Rule 86 Fed Reg 45544-45545 https://www.govinfo.gov/content/pkg/FR-2021-08-13/pdf/2021-16519.pdf . Published August 13, 2021. Correction Notice 86 Fed. Reg. 58026-58027. https://www.govinfo.gov/content/pkg/FR-2021-10-20/pdf/2021-22724.pdf . Published October 20, 2021. Tables 1A-1D. The payment rate shown is the standardized amount for facilities with a wage index greater than one. The average standard amounts shown also assume facilities receive the full quality update. The payment will also be adjusted by the Wage Index for specific geographic locality. Therefore, payment for a specific hospital will vary from the stated Medicare national average payment levels shown. Also note that any applicable coinsurance, deductible, and other amounts that are patient obligations are included in the national average payment amount shown.

CPT® PROCEDURE CODES

ASCs use CPT[1] codes for their services. Medicare payment for procedures performed in an ambulatory surgery center is generally based on Medicare's ambulatory patient classification (APC) methodology for hospital outpatient payment although Comprehensive APCs (C-APCs) are used only for hospital outpatient services and are not applied to procedures performed in ASCs. Alternately, payment to the ASC for some CPT codes is based on the physician fee schedule payment, particularly for procedures commonly performed in the physician office.

Each CPT code designated as a covered procedure in an ASC is assigned a comparable relative weight as under the hospital outpatient APC system. This is then converted to a flat payment amount using a conversion factor unique to ASCs. Multiple procedures can be paid for each claim. Certain ancillary services, such as imaging, are also covered when they are integral to covered surgical procedures, although they may not be separately payable. In general, there is no separate payment for devices; their payment is packaged into the payment for the procedure.

CPT CODE	DESCRIPTION	PAYMENT INDICATOR[2,3]	RELATIVE WEIGHT[2,4]	MEDICARE NATIONAL AVERAGE[2,4]	MULTIPLE PROCEDURE DISCOUNT[2]
22513	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic	G2	60.1201	$3,001	Y
22514	- lumbar	G2	60.1201	$3,001	Y
+22515	- each additional thoracic or lumbar vertebral body[5]	N1	N/A	N/A	N
0200T	Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used, 1 or more needles, includes imaging guidance and bone biopsy, when performed[6]	J8	78.2338	$3,905	Y
0201T	Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, 2 or more needles, includes imaging guidance and bone biopsy, when performed[6]	G2	60.1201	$3,001	Y

MULTIPLE PROCEDURES:
The kyphoplasty codes are subject to multiple procedure reduction when billed together with other procedure codes during the same encounter. Medicare pays 100% of the rate for the higher-valued code and pays the lower-valued code at 50% of the rate. Add-on code +22515 is not separately payable.

COMMERCIAL PAYERS:
Many non-Medicare payers use a similar type of fee schedule to determine payment to ASCs, although the specific payment amounts and other policies may differ. Commercial payers typically apply a similar multiple procedure discount when more than one procedure code is billed. Note that some commercial payers do not sort the codes by value and instead pay the first-listed code at 100% of the rate and reduce the second-listed code by the contracted percent. Other payers may use alternate payment methodologies. ASCs should check their specific commercial payer contracts for the payment provisions for each payer.

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2. Centers for Medicare & Medicaid Services. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems... Final Rule. 86 Fed Reg 63761-63815. https://www.govinfo.gov/content/pkg/FR-2021-11-16/pdf/2021-24011.pdf . Published November 16, 2021.
3. The Payment Indicator shows how a code is handled for payment purposes. J8 = device-intensive procedure, payment amount adjusted to incorporate device cost; G2 = surgical procedure, non-office-based, payment based on hospital outpatient rate adjusted for ASC; N1 = packaged service, no separate payment.
4. Medicare national average payment is determined by multiplying the ASC weight by the ASC conversion factor. The 2022 ASC conversion factor is $49.916. The conversion factor of $49.916 assumes the ASC meets quality reporting requirements. Centers for Medicare & Medicaid Services. Medicare Program: Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment Systems... Final Rule. 86 Fed Reg 63815. https://www.govinfo.gov/content/pkg/FR-2021-11-16/pdf/2021-24011.pdf . Published November 16, 2021. Payment is adjusted by the wage index for each ASC's specific geographic locality, so payment will vary from the national average Medicare payment levels displayed. Also note that any applicable coinsurance, deductible, and other amounts that are patient obligations are included in the national average payment amount shown.
5. The provider may report only one primary procedure code plus the add-on code +22515 for each additional level regardless of whether the additional level(s) are contiguous or not, per National Correct Coding Initiative (NCCI) Policy Manual 1/1/2022, Chapter IV, F.4.
6. Codes 0200T and 0201T are used for kyphoplasty of the sacrum (sacroplasty). Code 0200T is defined as "unilateral" and represents kyphoplasty of either the right or left side of the sacrum, regardless of the number of sacral levels. Code 0201T is defined as "bilateral" and represents kyphoplasty of both the right and left side of the sacrum, regardless of the number of sacral levels. See also CPT Assistant April 2015, p.8.

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