Billing and Coding
RAD-032 Vertebroplasty (Percutaneous) and Vertebral Augmentation Including Cavity Creation

Contractor Name
Wisconsin Physicians Service (WPS)

Contractor Number
00951, 00952, 00953, 00954
05101, 05201, 05301, 05401,
05102, 05202, 05302,
05402, 52280

Contractor Type
Carrier
Fiscal Intermediary (FI)
MAC – A
MAC – B

CMS National Coverage Policy
Title XVIII of the Social Security Act section 1862 (a)(1)(A). This section allows coverage and payment of those services that are considered to be medically reasonable and necessary.

Title XVIII of the Social Security Act section 1862 (a)(7). This section excludes routine physical examinations and services

Title XVIII of the Social Security Act section 1833 (e). This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Coding Guidelines
1. Percutaneous vertebroplasty of one vertebral body must be reported as 22520 for thoracic and 22521 for lumbar injection, unilateral or bilateral.
2. Bill CPT code 22522 for each additional vertebral body on which the procedure is performed during the same session. Do not append modifier 51, since this is an add-on code. Use 22522 in conjunction with codes 22520 or 22521 as appropriate.
3. Vertebral augmentation including cavity creation of one vertebral body must be reported as 22523 for thoracic and 22524 for lumbar injection, unilateral or bilateral.
4. Vertebral augmentation including cavity creation should be billed 22525 for each additional vertebral body on which the procedure is performed during the same session. Do not append modifier 51, since this is an add-on code. Use 22525 in conjunction with codes 22523 or 22524 as appropriate.
5. If more than one level is treated, multiple surgery billing guidelines apply.

6. Radiologic supervision and interpretation may be separately reported using CPT code 72291 use for fluoroscopic guidance or CPT code 72292 for CT guidance, for each vertebral body for which percutaneous vertebroplasty or vertebral augmentation including cavity creation is performed.
7. When billing for osteoporosis (733.00-733.09) that results in a pathologic fracture (733.13) or a fracture of the spinal column without spinal cord injury (805.00-805.08, 805.2, 805.4) both the osteoporosis code (733.00-733.09) and a fracture code (733.13, 805.00-805.08, 805.2, 805.4) must be on the claim.
8. ICD 9 code 255.0 (Cushing Syndrome) must be billed as a secondary diagnosis to code 995.20 to indicate steroid-induced osteoporosis and fracture
9. The procedure carries a 10-day "global fee" period. E&M services on the day of the procedure and during the 10-day post-op period generally are not payable with the exception of significant, separately identifiable E&M service. In this situation, append modifier 25 to the E&M code, if appropriate.
10. Standard payment adjustment rules for the multiple procedures apply. The first procedure is allowed 100% of the fee schedule and the additional at 50% except for the add-on code.
11. Do not use bilateral modifier 50 with the procedure codes. The procedure is per vertebral body, unilateral or bilateral.
12. No separate payment for venography performed during the operative session may be allowed.
13. Some physicians are erroneously billing for open vertebroplasty surgeries, using the code for percutaneous vertebroplasty. These surgeries are performed during various open spinal procedures such as the open treatment of vertebral fractures/dislocations (CPT 22325-22328) and various laminotomy/decompression procedures (CPT 63003-63091).
14. Since CPT codes 22520-22521 include localization of the vertebra (e) to be injected, they are not appropriate to use for open vertebroplasty; the localization has been accomplished through the surgical incision, and is therefore, included by the use of the primary procedure code(s).
15. To bill for open vertebroplasty that was performed with other open spinal procedures, use code 22899 (NOC). Place the name of the procedure "Open Vertebroplasty" in Item 19 of the CMS 1500 form or its equivalent when billing EMC. Bill for the number of vertebral levels injected, whether unilateral or bilateral. This code should not be reported for any vertebral level on which another procedure is already being performed on a vertebral body, such as open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s) (22325-22328).
16. Bone biopsy, (CPT code 20225, 20250 or 20251) unless performed as a separate procedure on a different body site, is considered integral to both Vertebroplasty (Percutaneous) and vertebral augmentation including cavity creation AND THUS NOT BILLABLE SEPARATELY.
17. If a bone biopsy is billed as a separate procedure, use modifier 59 to identify when the biopsy code is a distinct and separate service from the Vertebroplasty (percutaneous) or vertebral augmentation including cavity creation. Identify the site (such as L1) in item 19 of the CMS-1500 form or its electronic equivalent.
18. CPT code 62292 (Injection procedure for chemonucleolysis, including discography, intervertebral disk, single or multiple levels, lumbar) is not considered to be a procedure that is performed as part of Percutaneous Vertebroplasty or vertebral augmentation including cavity creation.

Documentation Requirements

Documentation supporting the medical necessity of this item, such as ICD-9 codes, must be submitted with each claim. Claims submitted without such evidence will be denied as being not medically necessary.

The medical record must include documentation of the specific signs, symptoms and condition associated with the billed ICD-9 code. This information must be available to the carrier upon request. To establish

medical necessity the medical record must indicate that other non-invasive corrective medical treatment has been tried and failed.

Reasons for Denial

Does this LCD contain a "Least Costly Alternative" Provision?
No

Publication Date
06/01/2010

Revision History Number/Explanation
07/16/2010,

Notes:
Italicized font - represents CMS national policy language/wording copied directly from CMS Manuals or CMS Transmittals. Carriers are prohibited from changing national policy language/wording. Providers, through their associations/societies, should contact CMS to request changes to national policy through the Medicare Coverage Policy Process at http://www.cms/hhs.gov/coverage.