

Medtronic

Radiofrequency ablation (RFA) for painful bone tumors with or without Vertebroplasty or Kyphoplasty

2026 coding and payment guide

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Coding considerations for Physicians, Outpatient Hospitals and ASCs

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Vertebroplasty or Kyphoplasty following RFA of vertebrae

In general, CPT considers placement of bone filler to be an inherent component of the primary procedure. For example, when cement is injected strictly as a filler for the surgical defect resulting from the volume of bone ablated, it is not coded separately.^a

However, there are some specific circumstances when cement injection following RFA may be therapeutic, as vertebroplasty or part of kyphoplasty, such as:

- When the bone structure is damaged or unstable associated with the underlying malignant lesion and the ablation defect is characterized by the physician as a pathological fracture or microfracture
- The physician may elect to inject cement into the defect to fill the void, stabilize the weakened bone and any associated microfractures, reduce the risk of overt fracture, and palliate pain.
- Whether to code injection of cement separately as vertebroplasty or kyphoplasty following RFA of the vertebral bone depends on the clinical characteristics and significance of the defect as well as the nature of the injection procedure, as determined and documented by the physician.

Biopsy of bone performed with RFA

Biopsy of the bone lesion is sometimes performed together with ablation. When a biopsy is performed at the time of another more extensive procedure, including ablation, it can be separately coded if performed on a different lesion or if the decision to perform the ablation is based on the biopsy result. However, biopsy should not be coded separately if it is “performed and submitted for pathologic evaluation completed after performing the more extensive procedure.”^b

CPT code ¹	Description
20220	Biopsy, bone, trocar, or needle, superficial (eg, ilium, sternum, spinous process, ribs)
20225	Biopsy, bone, trocar, or needle, deep (eg, vertebral body, femur)
20240	Biopsy, bone, open, superficial (eg, sternum, spinous process, rib, patella, olecranon process, calcaneus, tarsal, metatarsal, carpal, metacarpal, phalanx)
20245	Biopsy, bone, open, deep (eg, humeral shaft, ischium, femoral shaft)

HCPCS II device codes

Device C-codes

Device	HCPCS II device codes ²	HCPCS II code description
Ablation catheter	C1886	Catheter, extravascular tissue ablation, any modality (insertable)
Cement	C1713	Anchor/screw for apposing bone-to-bone or soft tissue-to-bone (implantable) ^c
Balloons	C1889	Implantable/insertable device, not otherwise classified

The device C-codes above are applicable to this therapy. To determine if there is a C-code for a particular Medtronic device, [click here for a C-code finder](#) to search by model number, product name, C-code, C-code description, or product category.

Physician coding and payment

January 1, 2026 - December 31, 2026

RFA

A single CPT code identifies RFA of bone tumor, metastatic or benign, regardless of the site.

CPT code ¹	Description	Medicare work RVUs ³	Medicare national average for physician services provided in: ^{†,4}	
			Office	Facility
20982	Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis), including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed, radiofrequency ^d	6.84	\$3,485	\$322

RFA with Vertebroplasty

CPT code ¹	Description	Medicare work RVUs ³	Medicare national average for physician services provided in: ^{†,4}	
			Office	Facility
20982	Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis), including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed, radiofrequency ^d	6.84	\$3,485	\$322
Plus				
22510	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic	7.70	\$1,764	\$383
22511	- lumbosacral ^e	7.15	\$1,775	\$361
+ 22512	- each additional cervicothoracic or lumbosacral vertebral body ^f	3.90	\$740	\$181

RFA with Kyphoplasty

CPT code ¹	Description	Medicare work RVUs ³	Medicare national average for physician services provided in: ^{†,4}	
			Office	Facility
20982	Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis), including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed, radiofrequency ^d	6.84	\$3,485	\$322
Plus				
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	8.43	\$5,805	\$453
22514	- lumbar	7.79	\$5,810	\$424
+ 22515	- each additional thoracic or lumbar vertebral body ^f	3.90	\$2,980	\$189

Note: In CPT, the kyphoplasty codes involve a separate and distinct mechanical device, eg, an inflatable balloon or tamp, used in an intentional manner to further develop the defect into a purposeful cavity prior to cement injection.⁹

[†] Rates shown reflect the CY 2026 Medicare Physician Fee Schedule for clinicians who did not qualify as participants in Advanced Alternative Payment Model (APM). Physicians and other eligible clinicians who qualify as participants in an Advanced APM under the Quality Payment Program may receive higher payment rates.

Hospital outpatient coding and payment

Effective January 1, 2026 - December 31, 2026

RFA

A single CPT code identifies RFA of bone tumor, metastatic or benign, regardless of the site.

CPT code ¹	Description	APC ⁵	APC level	Status Indicator ^{5,h}	Relative weight ⁵	Medicare national average ⁵
20982	Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis), including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed, radiofrequency ^d	5116	Level 6	J1	195.9590	\$17,914

RFA with Vertebroplasty

Note: Although codes for vertebroplasty may be assigned, relative weight and payment are not shown below because RFA code 20982 is assigned to a higher ranked C-APC. Any VP/BKP performed during the same encounter is considered adjunctive and no separate payment is made.

CPT code ¹	Description	APC ⁵	APC level	Status Indicator ^{5,h}	Relative weight ⁵	Medicare national average ⁵
20982	Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis), including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency ^d	5116	Level 6	J1	195.9590	\$17,914
Plus						
22510	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic	5113	Level 3	J1	-	-
22511	- lumbosacral ^e	5113	Level 3	J1	-	-
+22512	- each additional cervicothoracic or lumbosacral vertebral body ^f	-	-	N	-	-

RFA with Kyphoplasty

Note: Although codes for Kyphoplasty may be assigned, relative weight and payment are not shown below because RFA code 20982 is assigned to a higher ranked C-APC. Any VP/BKP performed during the same encounter is considered adjunctive and no separate payment is made.

CPT code ¹	Description	APC ⁵	APC level	Status Indicator ^{5,h}	Relative weight ⁵	Medicare national average ⁵
20982	Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis), including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency ^d	5116	Level 6	J1	195.9590	\$17,914
Plus						
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	J1	-	-
22514	- lumbar	5114	Level 4	J1	-	-
+22515	- each additional thoracic or lumbar vertebral body ^f	-	-	N	-	-

Note: In CPT, the kyphoplasty codes involve a separate and distinct mechanical device, eg, an inflatable balloon or tamp, used in an intentional manner to further develop the defect into a purposeful cavity prior to cement injection.⁹

ASC coding and payment

January 1, 2026 - December 31, 2026

RFA

A single CPT code identifies RFA of bone tumor, metastatic or benign, regardless of the site.

CPT code ¹	Description	Payment indicator ^{6,i}	Multiple procedure discounting ⁶	Relative weight ⁶	Medicare national average ⁶
20982	Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis), including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed, radiofrequency ^d	G2	Y	164.3378	\$9,256

RFA with Vertebroplasty

CPT code ¹	Description	Payment indicator ^{6,i}	Multiple procedure discounting ⁶	Relative weight ⁶	Medicare national average ⁶
20982	Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis), including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed, radiofrequency ^d	G2	Y	164.3378	\$9,256
Plus					
22510	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic	G2	Y	29.2047	\$1,645
22511	- lumbosacral ^e	G2	Y	29.2047	\$1,645
+22512	- each additional cervicothoracic or lumbosacral vertebral body ⁶	N1	N	-	-
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	G2	Y	65.6144	\$3,696
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	G2	Y	65.6144	\$3,696

RFA with Kyphoplasty

CPT code ¹	Description	Payment indicator ^{6,i}	Multiple procedure discounting ⁶	Relative weight ⁶	Medicare national average ⁶
20982	Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis), including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed, radiofrequency ^d	G2	Y	164.3378	\$9,256
Plus					
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	Y	65.6144	\$3,696
22514	- lumbar	G2	Y	65.6144	\$3,696
+22515	- each additional thoracic or lumbar vertebral body ^f	N1	N/A	-	-
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 (eg, kyphoplasty), unilateral or bilateral cannulations, inclusive of all imaging guidance	G2	Y	120.8130	\$6,804
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 (eg, kyphoplasty), unilateral or bilateral cannulations, inclusive of all imaging guidance	G2	Y	120.8130	\$6,804

Note: In CPT, the kyphoplasty codes involve a separate and distinct mechanical device, eg, an inflatable balloon or tamp, used in an intentional manner to further develop the defect into a purposeful cavity prior to cement injection.⁹

Billing Multiple VP/BKP levels:

Medicare:

ASC complexity C-code C7507 is assigned for first level thoracic and any additional thoracic or lumbar vertebral bodies. ASC complexity C-code C7508 is assigned for first level lumbar and any additional lumbar or thoracic vertebral bodies. The C7507/C7508 codes are in lieu of reporting CPT codes 22513/22514 + 22515 for ASCs only.

Commercial Payers:

ASCs should check with the specific commercial payer to determine whether C7507/C7508 are to be reported for first level thoracic and any additional thoracic or lumbar vertebral bodies or whether CPT codes 22513 + 22515 should be reported.

Hospital inpatient coding and payment

Effective October 1, 2025 – September 30, 2026

RFA

The following ICD-10-PCS⁷ codes are assigned for RFA of bone tumors. Root operation 5-Destruction is used for ablation. The codes shown are for the common sites of bone tumor ablation; other codes are available for less common sites.

ICD-10-PCS procedure codes ⁷	Description
Thorax (Sternum, Ribs, Clavicle)	
0P503ZZ	Destruction of sternum, percutaneous approach
0P513ZZ	Destruction of 1 to 2 ribs, percutaneous approach
0P523ZZ	Destruction of 3 or more ribs, percutaneous approach
0P593ZZ	Destruction of right clavicle, percutaneous approach
0P5B3ZZ	Destruction of left clavicle, percutaneous approach
Vertebrae and Spine	
0P543ZZ	Destruction of thoracic vertebra, percutaneous approach
0Q503ZZ	Destruction of lumbar vertebra, percutaneous approach
Shoulder and Upper Arm	
0P553ZZ	Destruction of right scapula, percutaneous approach
0P563ZZ	Destruction of left scapula, percutaneous approach
0P5C3ZZ	Destruction of right humeral head, percutaneous approach
0P5D3ZZ	Destruction of left humeral head, percutaneous approach
0P5F3ZZ	Destruction of right humeral shaft, percutaneous approach
0P5G3ZZ	Destruction of left humeral shaft, percutaneous approach
Pelvis, Upper Leg, and Lower Leg	
0Q513ZZ	Destruction of sacrum, percutaneous approach
0Q553ZZ	Destruction of coccyx, percutaneous approach
0Q523ZZ	Destruction of right pelvic bone, percutaneous approach
0Q533ZZ	Destruction of left pelvic bone, percutaneous approach
0Q543ZZ	Destruction of right acetabulum, percutaneous approach
0Q553ZZ	Destruction of left acetabulum, percutaneous approach
0Q563ZZ	Destruction of right upper femur, percutaneous approach
0Q573ZZ	Destruction of left upper femur, percutaneous approach
0Q583ZZ	Destruction of right femoral shaft, percutaneous approach
0Q593ZZ	Destruction of left femoral shaft, percutaneous approach
0Q5B3ZZ	Destruction of right lower femur, percutaneous approach
0Q5C3ZZ	Destruction of left lower femur, percutaneous approach
0Q5G3ZZ	Destruction of right tibia, percutaneous approach
0Q5H3ZZ	Destruction of left tibia, percutaneous approach
0Q5J3ZZ	Destruction of right fibula, percutaneous approach
0Q5K3ZZ	Destruction of left fibula, percutaneous approach

Hospital inpatient coding and payment (continued)

Biopsy of bone

Biopsy of the bone lesion is sometimes performed together with ablation and, when performed, is coded separately in ICD-10-PCS.† Root operation B-Excision with qualifier X-Diagnostic is used for biopsy

ICD-10-PCS procedure codes ⁷	ICD-10-PCS procedure code description
Thorax (Sternum, Ribs, Clavicle)	
0PB03ZX	Excision of sternum, percutaneous approach, diagnostic
0PB13ZX	Excision of 1 to 2 ribs, percutaneous approach, diagnostic
0PB23ZX	Excision of 3 or more ribs, percutaneous approach, diagnostic
0PB93ZX	Excision of right clavicle, percutaneous approach, diagnostic
0PBB3ZX	Excision of left clavicle, percutaneous approach, diagnostic
Vertebrae and Spine	
0PB43ZX	Excision of thoracic vertebra, percutaneous approach, diagnostic
0QB03ZX	Excision of lumbar vertebra, percutaneous approach, diagnostic
Shoulder and Upper Arm	
0PB53ZX	Excision of right scapula, percutaneous approach, diagnostic
0PB63ZX	Excision of left scapula, percutaneous approach, diagnostic
0PBC3ZX	Excision of right humeral head, percutaneous approach, diagnostic
0PBD3ZX	Excision of left humeral head, percutaneous approach, diagnostic
0PBF3ZX	Excision of right humeral shaft, percutaneous approach, diagnostic
0PBG3ZX	Excision of left humeral shaft, percutaneous approach, diagnostic
Pelvis, Upper Leg, and Lower Leg	
0QB13ZX	Excision of sacrum, percutaneous approach, diagnostic
0QBS3ZX	Excision of coccyx, percutaneous approach, diagnostic
0QB23ZX	Excision of right pelvic bone, percutaneous approach, diagnostic
0QB33ZX	Excision of left pelvic bone, percutaneous approach, diagnostic
0QB43ZX	Excision of right acetabulum, percutaneous approach, diagnostic
0QB53ZX	Excision of left acetabulum, percutaneous approach, diagnostic
0QB63ZX	Excision of right upper femur, percutaneous approach, diagnostic
0QB73ZX	Excision of left upper femur, percutaneous approach, diagnostic
0QB83ZX	Excision of right femoral shaft, percutaneous approach, diagnostic
0QB93ZX	Excision of left femoral shaft, percutaneous approach, diagnostic
0QBB3ZX	Excision of right lower femur, percutaneous approach, diagnostic
0QBC3ZX	Excision of left lower femur, percutaneous approach, diagnostic
0QBG3ZX	Excision of right tibia, percutaneous approach, diagnostic
0QBH3ZX	Excision of left tibia, percutaneous approach, diagnostic
0QBJ3ZX	Excision of right fibula, percutaneous approach, diagnostic
0QBK3ZX	Excision of left fibula, percutaneous approach, diagnostic

Hospital inpatient coding and payment (continued)

Vertebroplasty

Placement of bone void filler separately codable in ICD-10-PCS, regardless of whether cement is injected strictly as filler for a surgical defect or whether its injection constitutes vertebroplasty.^k Further, placement of bone void filler and vertebroplasty use the same ICD-10-PCS codes. The root operation is U-Supplement and device value J-Synthetic Substitute is used for the cement.^l

ICD-10-PCS procedure codes ⁷	ICD-10-PCS procedure code description
0PU43JZ	Supplement thoracic vertebra with synthetic substitute, percutaneous approach
0QU03JZ	Supplement lumbar vertebra with synthetic substitute, percutaneous approach
0QU13JZ	Supplement sacrum with synthetic substitute, percutaneous approach

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 always 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. In effect, kyphoplasty is coded as vertebral height restoration with cement injection.^{l,m}

ICD-10-PCS procedure codes ⁷	ICD-10-PCS procedure 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

MS-DRG assignments

RFA

When ablation of bone metastases or benign tumors is performed, without any additional procedures during the same inpatient admission, the following DRGs are typically assigned.

Ablation of Bone Neoplasm: Thorax (metastases only), Vertebrae & Spine, Shoulder & Upper Arm, Pelvis and Lower Leg

MS-DRG ⁸	MS-DRG title ^{8,n}	Relative weight ⁹	Medicare national Average ⁹
495	Local excision and removal of internal fixation devices except hip and femur W MCC	3.6257	\$26,383
496	Local excision and removal of internal fixation devices except hip and femur W CC	1.8039	\$13,127
497	Local excision and removal of internal fixation devices except hip and femur WO CC/MCC	1.1517	\$8,381

Ablation of bone neoplasm: upper leg (Femur)

498	Local excision and removal of internal fixation devices of hip and femur W CC/MCC	3.0168	\$21,953
499	Local excision and removal of internal fixation devices of hip and femur WO CC/MCC	2.0148	\$14,661

Ablation of bone neoplasm: thorax (benign only)

166	Other respiratory system O.R. procedures W MCC	3.7377	\$27,198
167	Other respiratory system O.R. procedures W CC	1.8034	\$13,123
168	Other respiratory system O.R. procedures WO CC/MCC	1.3664	\$9,943

RFA with biopsy

When bone biopsy is performed with ablation of bone metastases or benign tumors, the biopsy procedure code takes precedence and the following DRGs are typically assigned.

Ablation and biopsy of bone neoplasm: Thorax (metastases only), vertebrae and spine, shoulder and upper arm, pelvis, upper leg and lower leg

MS-DRG ⁸	MS-DRG title ^{8,n}	Relative weight ⁹	Medicare national average ⁹
477	Biopsies of musculoskeletal system and connection tissue W MCC	3.4546	\$25,138
478	Biopsies of musculoskeletal system and connection tissue WCC	2.4592	\$17,895
479	Biopsies of musculoskeletal system and connection tissue WO CC/MCC	1.8589	\$13,527

Ablation of bone neoplasm: thorax (benign only)

166	Other respiratory system O.R. procedures W MCC	3.7377	\$27,198
167	Other respiratory system O.R. procedures W CC	1.8034	\$13,123
168	Other respiratory system O.R. procedures WO CC/MCC	1.3664	\$9,943

RFA with Vertebroplasty or Kyphoplasty (no biopsy)

MS-DRG ⁸	MS-DRG title ^{8,n}	Relative weight ⁹	Medicare national average ⁹
495	Local excision and removal of internal fixation devices except hip and femur W MCC	3.6257	\$26,383
496	Local excision and removal of internal fixation devices except hip and femur W CC	1.8039	\$13,127
497	Local excision and removal of internal fixation devices except hip and femur WO CC/MCC	1.1517	\$8,381

RFA with Vertebroplasty or Kyphoplasty (with biopsy)

MS-DRG ⁸	MS-DRG title ^{8,n}	Relative weight ⁹	Medicare national average ⁹
477	Biopsies of musculoskeletal system and connection tissue W MCC	3.4546	\$25,138
478	Biopsies of musculoskeletal system and connection tissue W CC	2.4592	\$17,895
479	Biopsies of musculoskeletal system and connection tissue WO CC/MCC	1.8589	\$13,527

Annual references

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2. HCPCS 2025 Level II Professional Edition. American Medical Association; 2024. These codes are used by the entity that purchased and supplied the medical device. For Medicare hospital outpatient claims, C codes are required. For Medicare ASC claims, C codes are not reported unless the device is eligible for transitional pass-through payment. For non-Medicare hospital or ASC claims, please consult payer specific contracts for whether C or L codes would be billed.
3. PFS 2026 Final Rule CMS-1832-F Addenda. Cms.gov. Published October 31, 2025. <https://www.cms.gov/files/zip/cy-2026-pfs-final-rule-addenda.zip>. Although the total RVU consists of three components, only the physician work RVU is shown.
4. PFS 2026 Final Rule CMS-1832-F | CMS. Cms.gov. Published October 31, 2025. <https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1832-f>. Local physician rates will vary based on location specific factors not reflected in this document.
5. OPFS 2026 Final Rule CMS-1834-FC | CMS. Cms.gov. Published November 21, 2025. <https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1834-fc>. Rates shown reflect the unadjusted OPFS payment rates. Actual reimbursement may vary based on hospital-specific factors, such as wage index, geographic adjustments, and other CMS payment modifiers.
6. ASC 2026 Final Rule CMS-1834-FC | CMS. Cms.gov. Published November 21, 2025. <https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-regulations-and-notices/cms-1834-fc>. Rates shown reflect the unadjusted ASC payment rates. Actual reimbursement may vary based on hospital-specific factors, such as wage index, geographic adjustments, and other CMS payment modifiers.
7. AAPC. *ICD-10-PCS Code Book 2026*. AAPC; 2025.
8. CMS. ICD-10-CM/PCS MS-DRG v43.0 Definitions Manual. Cms.gov. Published 2025. https://www.cms.gov/icd10m/FY2026-fr-v43-fullcode-cms/fullcode_cms/P0001.html
9. FY 2026 IPPS Final Rule Home Page | CMS. Cms.gov. Published July 31, 2025. <https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2026-ippf-final-rule-home-page>. Rates shown reflect the unadjusted IPPS payment rates. Actual reimbursement may vary based on hospital-specific factors, such as wage index, geographic adjustments, and other CMS payment modifiers.

Important information

- a. See CPT Assistant, December 2012, p.12 and CPT Assistant, December 2021, p.19.
- b. National Correct Coding Initiative (NCCI) Policy Manual 1/1/2024, Chapter I, A.
- c. 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-Hospital Outpatient, Section 60.4.3. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf> .
- d. Code 20982 is reported once per operative episode, regardless of whether multiple lesions are treated in different bones. The Medically Unlikely Edit (MUE) value is 1 unit, with no appeal permitted. See also CPT Assistant, September 2015, p.12.
- e. Code 22511 is used for vertebroplasty of the lumbar vertebrae and sacral vertebrae per CPT Assistant April 2015, p.8.
- f. The provider may report only one primary procedure code plus the add-on code +22512 or +22515 for each additional level regardless of whether the additional level(s) are contiguous or not, per National Correct Coding Initiative (NCCI) Policy Manual 1/1/2023, Chapter IV, F.4.
- g. Endovascular Today, May 2017, “Vertebroplasty and Vertebral Augmentation Coding Revisited”, <http://evtoday.com/2017/05/vertebroplasty-and-vertebral-augmentation-coding-revisited?center=129>
- h. 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.
- i. The Payment Indicator shows how a code is handled for payment purposes. J8 = device-intensive procedure, payment amount adjusted to incorporate device cost; A2 = surgical procedure, payment based on hospital outpatient rate adjusted for ASC.
- j. ICD-10-PCS Official Guidelines for Coding and Reporting 2023, B3.4b.
- k. See Coding Clinic, 2nd Q 2013, p.35.
- l. See Coding Clinic, 2nd Q 2014, p.12.
- m. ICD-10-CM and ICD-10-PCS Coding Handbook 2022, Central Office on ICD-10-CM and ICD-10-PCS of the American Hospital Association, Chapter 22, Vertebroplasty and Kyphoplasty, p.318-319.

- n. 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.

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