

Medtronic

Vertebroplasty system

2026 coding and payment guide

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Physician coding and payment

January 1, 2026 - December 31, 2026

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CPT code	Description ¹	Medicare work RVUs ²	Medicare national average for physician services provided in: ^{†,3}	
			Office	Facility
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 ^a	7.15	\$1,775	\$361
+22512	- each additional cervicothoracic or lumbosacral vertebral body ^b	3.90	\$740	\$181

Multiple Procedures:

The vertebroplasty 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 +22512 is not subject to discounting and is always paid at 100% of the rate.

HCPCS II device codes

Device C-codes

Device	HCPCS II device codes ⁴	HCPCS II code description
Cement	C1713	Anchor/screw for apposing bone-to-bone or soft tissue-to-bone (implantable) ^c

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.

[†] 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

CPT code	Description ¹	APC ⁵	APC level	Status Indicator ^{5,d}	Relative weight ⁵	Medicare national average ⁵
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	36.5681	\$3,343
22511	- lumbosacral ^a	5113	Level 3	J1	36.5681	\$3,343
+22512	- each additional cervicothoracic or lumbosacral vertebral body ^b	-	-	N	-	-
22510 plus	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic	5114	Level 4	J1	81.0959	\$7,413
+25112	- each additional cervicothoracic or lumbosacral vertebral body ^b					
22511 plus	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral	5114	Level 4	J1	81.0959	\$7,413
+25112	- each additional cervicothoracic or lumbosacral vertebral body ^b					

ASC coding and payment

January 1, 2026 - December 31, 2026

CPT code	Description ¹	Payment indicator ^{6,e}	Multiple procedure discounting ⁶	Relative weight ⁶	Medicare national average ⁶
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 ^a	G2	Y	29.2047	\$1,645
+22512	- each additional cervicothoracic or lumbosacral vertebral body ^b	N1	N	N/A	N/A
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

Billing multiple Vertebroplasty levels:

Medicare:

ASC complexity C-codes C7504-C7505 should be assigned to report multi-level Vertebroplasty. CPT codes 22510-22512 for multi-level Vertebroplasty should not be reported to Medicare.

Commercial Payers:

ASCs should check with the specific commercial payer to determine whether C7504-C7505 are to be reported for multi-level Vertebroplasty procedures or whether CPT codes 22510-22512 should be reported.

Hospital inpatient coding and payment

Effective October 1, 2025 – September 30, 2026

Vertebroplasty

The following ICD-10-PCS codes are assigned for vertebroplasty procedures. Root operation U-Supplement is used for vertebroplasty and device value J-Synthetic Substitute is used for the cement.^{f,g}

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

Biopsy of vertebra

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

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

MS-DRG assignments

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.

Vertebroplasty for pathological fractures due to osteoporosis or malignancy

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

MS-DRG ⁸	MS-DRG title ^{8,h}	Relative weight ⁹	Medicare national average ⁹
515	Other musculoskeletal system and connective Tissue O.R. procedures W MCC	3.1869	\$23,190
516	Other musculoskeletal system and connective Tissue O.R. procedures W CC	2.0781	\$15,122
517	Other musculoskeletal system and connective Tissue O.R. procedures WO CC/MCC	1.5367	\$11,182

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

Annual references

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2. 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.
3. 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-notice/cms-1832-f>. Local physician rates will vary based on location specific factors not reflected in this document.
4. 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 the C code would be billed.
5. OPSS 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-notice/cms-1834-fc>. Rates shown reflect the unadjusted OPSS 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-notice/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. Code 22511 is used for vertebroplasty of the lumbar vertebrae and sacral vertebrae per CPT Assistant April 2015, p. 8.
- b. The provider may report only one primary procedure code plus the add-on code +22512 for each additional level regardless of whether the additional level(s) are contiguous or not, per National Correct Coding Initiative (NCCI) Policy Manual 1/1/2024, Chapter IV, F.4.
- 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>. 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. January 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS), p.4 <https://www.cms.gov/files/document/r4513cp.pdf>.
- d. 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; N = packaged service, no separate payment.
- e. The Payment Indicator shows how a code is handled for payment purposes. G2 = surgical procedure, non-office-based, payment based on hospital outpatient rate adjusted for ASC; N1 = packaged service, no separate payment
- f. 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.
- g. Coding Clinic, 2nd Q 2014, p.12.
- h. 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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