

Coding for Percutaneous Treatment of Vertebral Fractures

Clearing up use of the new codes for vertebroplasty and vertebral augmentation.

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New codes and introductory language that became effective January 1, 2015 to describe percu-

taneous treatment of vertebral fractures have raised questions from users, which this article attempts to address.

These new codes include the bundling of all imaging required to perform the procedure, moderate sedation, and bone biopsy when performed. Each Category I code (22510-22515) includes unilateral and bilateral injections, while the Category III codes for sacral augmentation specify unilateral (0200T) or bilateral (0201T) injection. In addition to bundling imaging with the surgical codes, the new codes for 2015 also changed sacral vertebroplasty from Category III level codes to Category I code 22511, and cervical vertebroplasty to Category I code 22510. Sacral vertebral augmentation continues to be reported with a Category III code (0200T, 0201T). Cervical vertebral augmentation is reported with unlisted code 22899.

NEW CODES

22510

Percutaneous vertebroplasty (bone biopsy included when performed), one vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic

22511

Lumbosacral

+ 22512

Each additional cervicothoracic or lumbosacral vertebral body

22513

Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), one vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic

22514

Lumbar

+ 22515

Each additional thoracic or lumbar vertebral body

0200T

Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used, one or more needles, includes imaging guidance and bone biopsy, when performed

0201T

Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, two or more needles, includes imaging guidance and bone biopsy, when performed

These two procedures both treat back pain secondary to vertebral compression fracture(s) using two separate techniques.

VERTEBROPLASTY

Vertebroplasty is performed to stabilize a fractured vertebra and prevent further collapse, which is accomplished by cement injection only into the vertebra through percutaneously placed transpedicular needles. No attempt to restore vertebral height or create a cavity for the cement is made with vertebroplasty. Code 22510 is reported for the initial cervical or thoracic vertebral body treated with vertebroplasty. Vertebroplasty performed to treat the initial lumbosacral vertebral body is reported with 22511. 22510 and 22511 are primary codes, and only one of these codes may be reported during a single session (both of these codes would not be reported together). Add-on code 22512 is used to report vertebroplasty performed on each additional level during the same session, regardless of whether the additional level is cervical, thoracic, lumbar, or sacral.

VERTEBRAL AUGMENTATION

A **vertebral augmentation** procedure attempts to restore height to a fractured vertebral body in addition to stabilizing the fracture. This is done by mechanical creation of a cavity within the vertebral body (for example, using a balloon, peek implant, or curette), followed by injection of cement into the cavity. Category I codes 22513 and 22514 describe vertebral augmentation in the initial treated thoracic or lumbar vertebral body, respectively. Code 22515 is an add-on code used to report vertebral augmentation for each additional vertebral body treated in the thoracolumbar spine during the same therapeutic session (22513 or 22514 is reported once for a single session, and these two codes are never reported together). Sacral vertebral augmentation is reported with Category III codes 0200T (unilateral) or 0201T (bilateral). Cervical vertebral augmentation may be reported with unlisted code 22899.

Historically, several terms have been used to describe vertebral augmentation procedures. Some of these terms include kyphoplasty, balloon kyphoplasty, balloon-assisted vertebroplasty, or percutaneous vertebroplasty augmentation including cavity creation using mechanical devices. The term “sacroplasty” has been used to describe both sacral vertebroplasty and sacral vertebral augmentation.

The terminology for these procedures can cause confusion for coders, which can be minimized by consciously and precisely using either “vertebroplasty” or

“vertebral augmentation” in operative reports to help distinguish what was performed and thus enabling coders to select the appropriate code(s) for reporting.

CODING CASE EXAMPLES

Case 1

A vertebroplasty is performed at T7 using bilateral transpedicular needle placement and injection of cement. Biplane fluoroscopic guidance.

Coding: 22510

Case 2

A vertebroplasty is performed at T7 using unilateral transpedicular needle placement and injection of cement. Biplane fluoroscopic guidance.

Coding: 22510

Case 3

A vertebroplasty is performed at T7 using bilateral transpedicular needle placement and injection of cement. CT guidance is used.

Coding: 22510 (Note that the new codes include all imaging guidance required to perform the procedure and do not distinguish between modalities.)

Case 4

Bilateral transpedicular needle placement is performed at T7. An aspiration biopsy of the vertebral body is performed, followed by bilateral injection of cement. CT guidance is used.

Coding: 22510 (Bone biopsy is included in the work described by this family of codes and is not separately reported.)

Case 5

A vertebroplasty is performed at T7 using bilateral transpedicular needle placement and injection of cement. A second level (T10) is treated with vertebroplasty also, using right transpedicular needle placement with cement injection. A combination of fluoroscopic and CT guidance is used.

Coding: 22510, 22512

Case 6

A vertebroplasty is performed at T7 using bilateral transpedicular needle placement and injection of cement. A second level (L2) is treated with vertebroplasty also, using bilateral transpedicular needle placement with cement injection. A combination of fluoroscopic and CT guidance is used.

Coding: This case could be reported correctly in two ways: 22510, 22512 **or** 22511, 22512

Discussion: Either the cervicothoracic or lumbosacral vertebroplasty could be considered the primary procedure and the other the add-on procedure. Because the work RVUs are slightly higher for 22510, most providers would choose to report cervicothoracic as the primary procedure in this case. (Note that in both options the add-on code 22512 is used to report the second level, because 22510 and 22511 may not be reported together.)

Case 7

A vertebroplasty is performed at L3 using bilateral transpedicular needle placement and injection of cement, using fluoroscopic guidance. A sacroplasty is performed at the S1 level using bilateral needle placement and cement injection under CT guidance.

Coding: 22511, 22512

Discussion: Even though different imaging modalities were required for treatment of the two levels, no additional code is reported, because this family of codes includes all imaging required to complete the procedures.

Case 8

Bilateral transpedicular needles are placed at T7. A balloon is advanced within the vertebral body and inflated to try to restore vertebral body height. The balloon is deflated and removed, and cement is injected into the cavity created by the balloon. Biplane fluoroscopic guidance is used.

Coding: 22513 (The procedure described is a vertebral augmentation.)

Case 9

Bilateral transpedicular needles are placed at L3. A curette is used to percutaneously create a small cavity within the vertebral body, followed by injection of cement into the cavity. Biplane fluoroscopic guidance is used. A similar procedure is performed at T10.

Coding: 22513, 22515 (The described procedures are vertebral augmentations.)

Case 10

Bilateral transpedicular needles are placed at L3. A curette is used to percutaneously create a small cavity within the vertebral body, followed by injection of cement into the cavity. Biplane fluoroscopic guidance is used. A similar procedure is performed at S2, using bilateral injections.

Coding: 22514, 0201T

Case 11

A unilateral transpedicular needle is placed at L3. A balloon is used to percutaneously create a small cavity

within the vertebral body, followed by injection of cement into the cavity. Biplane fluoroscopic guidance is used. A similar procedure is performed at S2, using unilateral needle placement, balloon creation of a small cavity, and cement injection into the cavity.

Coding: 22514, 0200T

Discussion: Note that for the lumbar vertebral augmentation, there is no difference in coding for unilateral or bilateral injection. However, with the sacral vertebral augmentation procedure, a different code is used to report unilateral versus bilateral injection.

Case 12

Bilateral needles are placed at S1, and cement is injected. At S3, a unilateral needle is placed, and cement is injected. Fluoroscopic guidance is used.

Coding: 22512

Discussion: Even when more than one level is treated in the sacrum, a single code is used to report the treatment.

Case 13

Bilateral transpedicular needles are placed at C7, and cement is injected. Biplane fluoroscopic guidance is used.

Coding: 22510 (This describes a cervical vertebroplasty.)

Case 14

Bilateral transpedicular needles are placed at C7. A small balloon is placed into the vertebral body and inflated to try to restore vertebral height. The balloon is deflated and removed, and cement is then injected into the cavity created by the balloon. Biplane fluoroscopic guidance is used.

Coding: 22899

Discussion: An unlisted code is used because there is no CPT code for vertebral augmentation in the cervical spine. It is not correct to use the cervical vertebroplasty code 22510 when a vertebral augmentation is performed. ■

Katharine L. Krol, MD, FSIR, FACR, is an interventional radiologist and has recently retired from active clinical practice. She has stated that she has no financial interests related to this topic.

CONTACT US

If you have any questions or topics you would like Dr. Krol to address in a future column, please contact us at evteditorial@bmctoday.com.