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Outpatient Facility Coding Alert

Pain Management: Don't Let Vertebroplasty Policy Differences Sideline Your Coding

Your first move is to identify vertebral locations.

The AMA and Medicare's recent differing guidance on vertebroplasty coding feels like clash of the titans, leaving coders wondering how to navigate two different sets of directions. Strengthen your claims by knowing Medicare's special guidelines for deciding which add-on codes apply.

Go Straight Down the List for AMA

If you're following AMA rules, your code choices are easy: simply report the parent code and each add-on in the code family as they're listed.

Example: The pain management physician completes vertebroplasty at spinal levels T12, L1, L2, and L3. AMA coding conventions (according to the March 2001 CPT® Assistant) recommend reporting the procedure as:

- 22520 (Percutaneous vertebroplasty [bone biopsy included when performed], 1 vertebral body, unilateral or bilateral injection; thoracic) for T12
- 22521 (Percutaneous vertebroplasty [bone biopsy included when performed], 1 vertebral body, unilateral or bilateral injection; lumbar) for L1; append modifier 51 (Multiple procedures) to differentiate the treatment from the one performed at T12.
- 22522 (... each additional thoracic or lumbar vertebral body [List separately in addition to code for primary procedure]) twice for L2 and L3.

Note: Physicians often perform vertebroplasty at one or two levels. Check whether your payer has limits of treatment or special ways to handle cases that involve more than two levels.

Also notice that the vertebroplasty codes carry the "bullseye" symbol in CPT®, meaning that you cannot separately bill moderate sedation with the procedures.

Watch Spinal Locations for CMS

Medicare guidelines, however, follow a different approach.

"The NCCI Manual was revised specifically addressing this issue," says **Marvel Hammer,** RN, CPC, CCS-P, PCS, ACS-PM, CHCO, owner of MJH Consulting in Denver, Co. "Whether Medicare allows a provider to additionally report the second parent code versus the add-on code is dependent upon whether the sites are contiguous (such as T12 and L1) or non-contiguous (such as T12 and L4)."

Rationale: Chapter 4 of the 2013 NCCI Manual discusses how many spinal procedures are grouped into code families with separate primary (or parent) procedure codes describing the procedure at a single vertebral level of the spine (cervical, thoracic, or lumbar). Some code families also include an add-on code for reporting the same procedure at each additional level without specifying a particular spinal region.

The guidelines state, "When multiple procedures from one of these families of codes are performed at contiguous vertebral levels, a physician should report only one primary code within the family of codes for one level and should report additional contiguous levels utilizing the add-on code(s) in the family of codes. The reported primary code should be the one corresponding to the spinal region of the first procedure."

Code distinctions: Percutaneous vertebroplasty code 22520 describes treatment of a single thoracic vertebral body. Code 22521 describes the procedure for a single lumbar vertebral body. The final code in the family, +22522, is an add-on code for percutaneous vertebroplasty of each additional thoracic or lumbar vertebral body.

Example 1: The physician performs percutaneous vertebroplasty on T12 and L1. Because these are contiguous vertebral bodies, you only report one primary procedure code the one for the first procedure and one add-on code. You should submit 22520 for T12 and +22522 for L1. Remember that since +22522 applies to either the thoracic or lumbar regions, you would also submit it as the second code if both contiguous vertebrae were in the thoracic region.

Multiple region consideration: Your coding changes if the physician performs multiple procedures from one of the spinal code families at multiple vertebral levels that are not contiguous and are in different spinal regions. In this situation, CCI Manual guidelines direct you to report one primary code for each non-contiguous region.

Example 2: The physician performs the procedure at T9 and L4. In this scenario, you're coding for non-contiguous vertebral bodies in different spinal regions. Submit 22520 for T9 and 22521 for L4.