

Part B Insider (Multispecialty) Coding Alert

NEUROSURGERY: Reader Question--Cut Out Modifiers When You Code For Vertebroplasty

Question: We have documentation that the neurosurgeon performed vertebroplasty at more than one spinal level during the same operative session. I'm not sure how to code this. Do I need an add-on code?

Illinois Subscriber

Answer: Yes, you should report each additional level using add-on code +22522 (Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection each additional thoracic or lumbar vertebral body). Code the primary level and then use this add-on code for the subsequent levels, says **Patrick J. Cafferty, MPAS, PA-C, CHCO**, president and CEO of **Neurosurgical Associates of Western Kentucky**, a neurosurgery and pain management group.

Potential misstep: You don't have to apply modifier 51 (Multiple procedures) to [code 22522](#) because it is a designated add-on code and isn't subject to a multiple-procedure fee reduction. Sometimes, a neurosurgeon will treat vertebrae in both the thoracic and lumbar areas during the same operative session. In such cases, you must still choose only a single "primary" code (either 22520 or 22521) and use 22522 for each level beyond the first, even though the surgeon crosses spinal areas.

The primary code describes the injection, the physician's approach and closure, and the surgery's global fee. The add-on code covers only the additional level injection.

Example: Osteoporosis, a common condition treated using percutaneous vertebroplasty, often occurs at the thoracic/lumbar junction. If the physician injects vertebrae T12 and L1, you should report 22520 (for the primary thoracic level T12) and 22522 for the additional lumbar level L1.

Keep in mind: Medicare assigns a slightly higher value to 22520 than to 22521. Therefore, always choose 22520 as the primary code when the surgeon repairs vertebrae in both spinal areas.