Outpatient Facility Coding Alert

Reader Question: Use Add-On +22522 for Multilevel Vertebroplasty

Question: Our pain management physician performed a three-level vertebroplasty at T12, L1, and L2/L3 on a 47-year-old patient. What is the correct way to code the procedure?

Minnesota Subscriber

Answer: The AMA and Medicare may differ in how they recommend you report the procedure. Because the patient your physician treated isn't covered by Medicare, you'll follow the AMA's recommendation. The correct coding is:

- 22520 (Percutaneous vertebroplasty [bone biopsy included when performed], 1 vertebral body, unilateral or bilateral injection; thoracic) for T12
- 22521 (...lumbar) for L1
- +22522 (...each additional thoracic or lumbar vertebral body [List separately in addition to code for primary procedure]) x 2 for L2 & L3.

Note: If your provider treats more than one spinal level during the same operative session, report each additional level using add-on code +22522, as noted above. You'll list the add□on code in addition to the "primary level" code (22520 or 22521). 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.