

# KYPHON® Balloon Kyphoplasty Procedure

## Reimbursement Guide

### HOSPITAL

#### Hospital Inpatient Coding

##### ICD-9-CM Procedure Code

- » 81.66 Percutaneous vertebral augmentation

##### ICD-9-CM Diagnosis Codes

Most Medicare contractors have established Local Coverage Determinations (LCDs) which list medical indications of coverage and ICD-9-CM diagnosis codes that support medical necessity for KYPHON® Balloon Kyphoplasty procedures. The following diagnosis codes may apply to patients undergoing balloon kyphoplasty:

- » 733.13 Pathologic fracture of vertebrae
- » 733.XX Osteoporosis
- » 2XX.XX Neoplasm; deficiency-related diagnoses
- » 8XX.XX Fracture diagnoses
- » Providers should report the ICD-9-CM code that most accurately describes a patient's condition. Please refer to payer policy in your region for more information. Multiple diagnosis codes may be required.

#### Possible Medicare-Severity Diagnosis-Related Groups (MS-DRGs)

- » 515 Other musculoskeletal system and connective tissue O.R. procedures with major complication or comorbidity (MCC)
- » 516 Other musculoskeletal system and connective tissue O.R. procedures with complication and/or comorbidity (CC)
- » 517 Other musculoskeletal system and connective tissue O.R. procedures without CC/MCC

When a vertebral biopsy is performed with a percutaneous vertebral augmentation procedure in the hospital inpatient setting, the hospital should assign code 77.49 (biopsy of bone, other) in addition to the code for the procedure (AHA Coding Clinic for ICD-9-CM-3rd Quarter, November 3, 2006). When the biopsy code is present, the DRG assignment for the case is modified to the following possible MS-DRGs:

- » 477 Biopsies of musculoskeletal system and connective tissue with MCC
- » 478 Biopsies of musculoskeletal system and connective tissue with CC
- » 479 Biopsies of musculoskeletal system and connective tissue without CC/MCC

Under the MS-DRG system, cases may be assigned to a number of other MS-DRGs, based on individual patient diagnosis and presence or absence of additional surgical procedures performed. Additional MS-DRGs include but are not limited to: MS-DRGs 907, 908, 909; MS-DRGs 957, 958, 959; and MS-DRGs 981, 982, 983.

#### Hospital Outpatient Coding

##### Procedure Codes

- » 22523 Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (e.g., kyphoplasty); thoracic
- » 22524 lumbar
- » 22525 each additional thoracic or lumbar vertebral body (list separately in addition to code for primary procedure)
- » 72291\* Radiological supervision and interpretation, percutaneous vertebroplasty or vertebral augmentation including cavity creation, per vertebral body; under fluoroscopic guidance
- » 72292\* under CT guidance

\*Payment is packaged in other services; therefore, there is no separate APC payment.

#### Medicare Ambulatory Payment Classification (APC)

- » APC 052 Level IV musculoskeletal procedures except hand and foot

#### Utilization Review

Physicians should confirm pertinent inpatient or outpatient admission criteria and make admission decisions based on medical necessity.

## AMBULATORY SURGERY CENTER

### Ambulatory Surgery Center (ASC)

#### Procedure Codes

- » 22523 Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (e.g., kyphoplasty); thoracic
- » 22524 lumbar
- » 22525 each additional thoracic or lumbar vertebral body (list separately in addition to code for primary procedure)
- » 72291\* Radiological supervision and interpretation, percutaneous vertebroplasty or vertebral augmentation including cavity creation, per vertebral body; under fluoroscopic guidance
- » 72292\* under CT guidance

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#### ICD-9-CM Diagnosis Codes

Most Medicare contractors have established local coverage Determinations (LCDs) which list medical indications of coverage and ICD-9-CM diagnosis codes that support medical necessity for KYPHON® Balloon Kyphoplasty procedures. The following diagnosis codes may apply to patients undergoing balloon kyphoplasty:

- » 733.13 Pathologic fracture of vertebrae
- » 733.XX Osteoporosis
- » 2XX.XX Neoplasm; deficiency-related diagnoses
- » 8XX.XX Fracture diagnoses
- » Providers should report the ICD-9-CM code that most accurately describes a patient's condition.
- » Please refer to payer policy in your region for more information. Multiple diagnosis codes may be required.

#### Documentation

- » Medical record documentation is key to communicating essential information for making a decision as to whether a procedure was reasonable and necessary for a particular patient.
- » At minimum, the medical record should convey information about a patient's medical condition, the rationale for why balloon kyphoplasty was needed, and the outcome of the procedure.
- » Medical record documentation should include a detailed history and physical, which enables billing personnel to verify that a claim is coded specifically and accurately. For example, some payers require documentation that conservative care has been tried and has failed.
- » See payer policy for specific documentation and clinical coverage criteria.

## PHYSICIAN

### CPT® Codes

- » 22523 Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (e.g., kyphoplasty); thoracic
- » 22524 lumbar
- » 22525 each additional thoracic or lumbar vertebral body (list separately in addition to code for primary procedure)
- » 72291-26 Radiological supervision and interpretation, percutaneous vertebroplasty or vertebral augmentation including cavity creation, per vertebral body; under fluoroscopic guidance
- » 72292-26 under CT guidance

### ICD-9-CM Diagnosis Codes

All claim forms must include ICD-9-CM diagnosis codes to report the patient's condition. These codes reflect the physician's assessment of a particular patient's condition. Most Medicare contractors have established Local Coverage Determinations (LCDs) which list medical indications of coverage and ICD-9-CM diagnosis codes that support medical necessity for KYPHON® Balloon Kyphoplasty procedures. The LCDs are available through the CMS website at [www.cms.hhs.gov/center/coverage.asp](http://www.cms.hhs.gov/center/coverage.asp). The following diagnosis codes may apply to patients undergoing balloon kyphoplasty:

- » 733.13 Pathologic fracture of vertebrae
- » 733.XX Osteoporosis
- » 2XX.XX Neoplasm; deficiency-related diagnoses
- » 8XX.XX Fracture diagnoses
- » Providers should report the ICD-9-CM code that most accurately describes a patient's condition.
- » Please refer to payer policy and ICD-9-CM diagnosis codes that support medical necessity in your region. Multiple diagnosis codes may be required.

### Documentation

- » Medical record documentation is key to communicating essential information for making a decision as to whether a procedure was reasonable and necessary for a particular patient.
- » At minimum, the medical record should convey information about a patient's medical condition, the rationale for why balloon kyphoplasty was needed, and the outcome of the procedure.
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- » See payer policy for specific documentation and clinical coverage criteria.

### Medical Necessity/Site of Service

Balloon kyphoplasty can be performed in an inpatient or outpatient hospital setting or in an Ambulatory Surgery Center (ASC). Medical necessity will dictate site of service for each individual patient. Please contact your medical facility for inpatient admission criteria.

### Prior Authorization

Assistance with a prior authorization or denial may be available from Medtronic for patients whose medical needs are consistent with FDA approved/cleared indications or are otherwise in accordance with payer policies.\* Prior authorization requests for balloon kyphoplasty may require the following items:

- » Progress notes
- » X-ray and/or MRI reports
- » Medicare or other coverage policies
- » Clinical literature (available from Medtronic upon request or at [www.kyphon.com](http://www.kyphon.com))

\*Contact Medtronic's Therapy Access Solutions at (866) 446-3873 for assistance.

[www.medtronicsofamordanek.com/spine](http://www.medtronicsofamordanek.com/spine)

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For additional coding information  
contact the SpineLine® Coding  
Support Line at (877) 690-5353.

Provider Relations Specialist:  
(888) 865-9512  
[www.kyphon.com/us/reimbursement](http://www.kyphon.com/us/reimbursement)

The complication rate with KYPHON® Balloon Kyphoplasty has been demonstrated to be low. As with all surgical procedures, there are risks associated with the procedure, including serious complications, and though rare, some of which may be fatal. For complete information regarding indications for use, contraindications, warnings, precautions, adverse events, and methods of use, please reference the devices' Instructions for Use included with the product.

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