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THE VERTIFLEX™ PROCEDURE†
2025 REIMBURSEMENT GUIDE

FOR MORE PROCEDURE PAYMENT GUIDES, CLICK HERE

This reimbursement guide, for The Vertiflex™ Procedure†, provides coding and payment information for physicians and facilities to receive Medicare reimbursement. The Medicare payment amounts provided are national average payments. Actual reimbursement will vary based on different factors.

Payer policies will vary and should be verified prior to treatment for limitations on diagnosis, coding, or site of service requirements. The coding options listed within this guide are commonly used codes and are not intended to be an all-inclusive list. We recommend consulting your relevant manuals for appropriate coding options.

This guide is intended to fully inform users. Sites of services must be based upon each patient's acuity of care needs.

INCLUDED IN THIS GUIDE:

Under each section in this guide are CPT codes and Medicare National Average Payments for physicians, Ambulatory Surgery Centers, Hospital Outpatient, and Hospital Inpatient.

1. The Vertiflex™ Procedure† Physician Reimbursement 2025
2. The Vertiflex™ Procedure† Ambulatory Surgery Center Reimbursement 2025
3. The Vertiflex™ Procedure† Hospital Outpatient Reimbursement 2025
4. The Vertiflex™ Procedure† Inpatient Hospital and Payment Guide, October 2024 – September 2025

THE VERTIFLEX™ PROCEDURE† PHYSICIAN REIMBURSEMENT 2025

2025 Coding and Payment Guide for Medicare Reimbursement: The following are the 2025 Medicare coding and national physician payments rates for the insertion of interspinous spacers.

CPT[1,2]	DESCRIPTION	GLOBAL PERIOD	WORK RVUS[3]	TOTAL RVUS[3]	NON-FACILITY NATIONAL AVERAGE PAYMENT[4]	FACILITY NATIONAL AVERAGE PAYMENT[4]
Interspinous Spacer Coding						
22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	90	7.03	13.01	N/A	$421
22870	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)	ZZZ[5]	2.34	3.49	N/A	$113

ICD-10-CM DIAGNOSIS CODE[6]	
M48.062	Spinal stenosis, lumbar region with neurogenic claudication

THE VERTIFLEX™ PROCEDURE† AMBULATORY SURGERY CENTER REIMBURSEMENT 2025

Coding and Payment Guide for Medicare Reimbursement: The following are the 2025 Medicare coding and national payment rates for Interspinous Spacer procedures performed in an ambulatory surgical center.

CPT®[1]	DESCRIPTION	MULTIPLE PROCEDURE DISCOUNTING[7]	STATUS INDICATOR[8]	MEDICARE NATIONAL AVERAGE PAYMENT[4]
Interspinous Spacer Coding				
22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	Y	J8	$10,878
22870	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)	N	N1	Packaged

THE VERTIFLEX™ PROCEDURE†
HOSPITAL OUTPATIENT REIMBURSEMENT 2025

Coding and Payment Guide for Medicare Reimbursement: The following are the 2025 Medicare coding and national payment rates for Interspinous Spacer procedures performed in the outpatient hospital setting. Comprehensive Ambulatory Payment Classification (C-APCs) are effective for services performed in an Outpatient Hospital. A Comprehensive APC, "C-APC" is a single all-inclusive payment for a primary device dependent service and all adjunct services provided to support the delivery of the primary service. APCs with a status indicator of, "J1," have been designated by CMS as comprehensive APCs.

CPT®[1]	DESCRIPTION	APC[9]	STATUS INDICATOR[10]	MEDICARE NATIONAL AVERAGE PAYMENT[4]
Interspinous Spacer Coding				
22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	5115	J1	$12,867
22870	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)	N/A	N	Packaged

HCPCS LEVEL II DESCRIPTORS	
C1821	Interspinous process distraction device (implantable)

THE VERTIFLEX™ PROCEDURE†
INPATIENT HOSPITAL AND PAYMENT GUIDE

October 2024 – September 2025

Coding and Payment Guide for Medicare Reimbursement: The information below represents FY2025 Medicare coding and base payment rates for Interspinous Spacer procedures performed in the inpatient hospital setting. The inpatient system uses Medical Severity Diagnosis Related Groups (MS-DRGs) to align resources associated with the patient's diagnosis. The most common MS- DRGs for Interspinous Spacer procedures are outlined below. This does not represent an exhaustive list of Interspinous Spacer procedures.

ICD-10 PROCEDURE CODES ASSOCIATED WITH INTERSPINOUS SPACERS

ICD-10-PCS[11]	DESCRIPTION
0SH03BZ	Insertion of Interspinous Process Spinal Stabilization Device into Lumbar Vertebral Joint, Percutaneous Approach

MS-DRGS ASSOCIATED WITH INTERSPINOUS SPACERS[12]

MS-DRG	DESCRIPTION	BASE PAYMENT[13]
518	Back and Neck Procedures Except Spinal Fusion with MCC or Disc Device/Neurostimulation	$25,577

BOSTON SCIENTIFIC PATIENT THERAPY ACCESS

For help with **accelerating benefit verification, prior authorization,** and **appeals,** contact our patient therapy access team. This team consists of prior authorization certified specialists who are dedicated to your practice. Submit and track your cases through Boston Scientific's **HIPAA-compliant online portal** that has a practice dashboard with **real-time patient access updates.**

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Call: (866) 287-0778 The Vertiflex™ Procedure†

†Superion® Indirect Decompression System

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2. Multiple procedure reduction rules apply for procedures (excluding programming codes). Quantity of devices used in each procedure must be specified for appropriate payment. Payment rates provided are Medicare national average rates for each specified procedure with quantity = 1.
3. Department of Health and Human Services. Centers for Medicare and Medicaid Services. The 2025 National Average Medicare physician payment rates have been calculated using a revised conversion factor of 32.7442 which reflects changes effective as of calendar year 2025.
4. "National Average Payment" is the amount Medicare determines to be the maximum allowance for any Medicare covered procedure. These are national average payment amounts, individual payments may vary based on locality and Medicare's geographic adjustments. Actual payment will vary based on the maximum allowance less any applicable deductibles, co-insurance etc.
5. ZZZ: Add-on code that you must bill with another service. No post-operative work included.
6. ICD-10-CM Expert for Physicians: The Complete Official Code Set. Optum360, 2024.
7. In the case that multiple procedures are billed and coded, payment is typically made at 100% of the rate for the first procedure, and 50% of the rate for the second and all succeeding procedures. Such procedures subject to this discount are marked "Y". However, procedure marked "N" are not subject to discounting, and are paid at 100% full, regardless of whether they are submitted with other procedures.
8. ASC Status indicators: J8: Device-intensive procedure; paid at adjusted rate. N1: Packaged service/item; no separate payment made.
9. 42 CFR Parts 411, 412, 416, 419, 422, 423, 424 [CMS-1786-FC]
10. J1: Hospital Part B services paid through a comprehensive APC. N: Items and Services Packaged into APC Rates
11. CMS 2024 ICD-10-PCS Code Set Reference
12. Most common MS-DRGs for Interspinous Spacers procedures based on Medicare claims data. Boston Scientific does not promote the use of its products outside FDA approval label.
13. Medicare National average base MS-DRG payment amounts (for urban areas) as of October 1, 2024 based on most common diagnoses for Interspinous Spacers. These are national average payment amounts, individual payments may vary based on locality and Medicare's geographic adjustments. Academic teaching and disproportionate share hospitals may qualify for additional payment amounts in addition to the base MS-DRG.

Indications for Use: The Superion™ Indirect Decompression System (IDS) is indicated to treat skeletally mature patients suffering from pain, numbness, and/or cramping in the legs (neurogenic intermittent claudication) secondary to a diagnosis of moderate degenerative lumbar spinal stenosis, with or without Grade 1 spondylolisthesis, having radiographic evidence of thickened ligamentum flavum, narrowed lateral recess, and/or central canal or foraminal narrowing. The Superion™ Interspinous Spacer is indicated for those patients with impaired physical function who experience relief in flexion from symptoms of leg/buttock/groin pain, with or without back pain, who have undergone at least 6 months of non-operative treatment. The Superion Interspinous Spacer may be implanted at one or two adjacent lumbar levels in patients in whom treatment is indicated at no more than two levels, from L1 to L5. Contraindications, warnings, precautions, side effects. The Superion Indirect Decompression System (IDS) is contraindicated for patients who: have spinal anatomy that prevent implantation of the device or cause the device to be unstable in situ (i.e., degenerative spondylolisthesis greater than grade 1), Cauda equina syndrome, or prior decompression or fusion at the index level. Refer to the Instructions for Use provided on www.vertiflex.com for additional Indications for Use, contraindications information and potential adverse effects, warnings, and precautions prior to using this product. Caution: U.S. Federal law restricts this device to sale by or on the order of a physician.

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