



Medicare Part C Medical Coverage Policy

Vertebroplasty and Percutaneous Vertebral Augmentation

Origination Date: December 16, 2002 Vertebroplasty

August 20, 2003 Kyphoplasty

Review Date: June 17, 2020

Next Review: June, 2022

******This policy applies to all Blue Medicare HMO, Blue Medicare PPO, Blue Medicare Rx members, and members of any third-party Medicare plans supported by Blue Cross NC through administrative or operational services. ******

DESCRIPTION OF PROCEDURE OR SERVICE

Vertebroplasty

Percutaneous vertebroplasty is a therapeutic, interventional radiologic procedure, which consists of the injection of a biomaterial (usually polymethylmethacrylate- bone cement) under imaging guidance (either fluoroscopy or CT) into a cervical, thoracic or lumbar vertebral body lesion for the relief of pain and the strengthening of bone.

Percutaneous Vertebral Augmentation

This is also known as balloon-assisted Percutaneous Vertebroplasty or Kyphoplasty. The procedure is similar to percutaneous vertebroplasty in that stabilization of the collapsed vertebra is accomplished by the injection of the same biomaterial into the body of the vertebra.

The primary difference is that the fracture is partially reduced with the insertion of an inflatable balloon tamp. Once inflated, the balloon tamp (plug) restores some height to the vertebral body, while creating a cavity that is filled with bone cement.

POLICY STATEMENT

Coverage will be provided for vertebroplasty or percutaneous vertebral augmentation when it is determined to be medically necessary because the medical criteria and guidelines shown below are met.

BENEFIT APPLICATION

Please refer to the member's individual Evidence of Coverage (EOC) for benefits.

Coverage decisions will be made in accordance with:

- The Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCDs);

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- General coverage guidelines included in Original Medicare manuals unless superseded by operational policy letters or regulations; and
- Written coverage decisions of local Medicare carriers and intermediaries with jurisdiction for claims in the geographic area in which services are covered.

Benefit payments are subject to contractual obligations of the Plan. If there is a conflict between the general policy guidelines contained in the Medical Coverage Policy Manual and the terms of the member's particular Evidence of Coverage (EOC), the EOC always governs the determination of benefits.

INDICATIONS FOR COVERAGE

A. The principal indications for Percutaneous Vertebroplasty are as follows:

1. Osteolytic vertebral metastasis and/or myeloma with severe back pain related to a destruction of the vertebral body, not involving the major part of the cortical bone;
2. Vertebral hemangiomas or eosinophilic granulomas of the spine with aggressive clinical signs (severe pain or nervous compression) and/or aggressive radiological signs;
3. Steroid induced fractures (pathological fracture of vertebrae);
4. Osteoporotic vertebral collapse with persistent debilitating pain which has not responded to less invasive medical treatment (e.g., trial of clinically appropriate analgesic medications, skilled therapies, restricted activity/bracing, or other noninvasive treatments);
5. Unstable fractures due to osteoporosis, (Kummell's Disease).

B. The indications for Percutaneous Vertebral Augmentation are as follows:

1. Osteolytic vertebral metastasis and/or myeloma with severe back pain related to a destruction of the vertebral body, not involving the major part of the cortical bone.
2. Painful, debilitating osteoporotic vertebral collapse/compression fractures that have not responded to adequate medical treatment, (e.g., a period of immobilization such as restricted activity/bracing and analgesia/scheduled narcotic).

For both percutaneous vertebroplasty and vertebral augmentation, the decision for treatment should take into consideration the local and general extent of the disease. This includes the spinal level involved, the severity of pain experienced by the patient, his/her neurologic condition, previous treatments and their outcomes, the general state of health and life expectancy.

Contraindications for both Vertebroplasty and Percutaneous Vertebral Augmentation

A. **Absolute Contraindications for both procedures:**

1. Uncorrected coagulation disorders or anticoagulation therapy;
2. Asymptomatic vertebral compression fracture;
3. Osteomyelitis or local infection;

4. Burst fracture with retropulsed fragments;
5. Known allergy to materials used in either procedure.

B. Absolute Contraindications for Percutaneous Vertebral Augmentation - only:

1. Painful benign neoplasm's;
2. Fractures caused by high-velocity injury;
3. Other causes of back pain not due to fracture;
4. Associated with widened pedicles or retropulsion of bone/ burst fracture.

C. Relative Contraindications for Vertebroplasty:

1. Extensive and/or significant vertebral collapse or significant neurological symptoms related to compression of the vertebrae.

D. Relative Contraindications for Percutaneous Vertebral Augmentation:

1. Extensive vertebral destruction;
2. Significant vertebral collapse and;
3. Systemic or local infections.

LIMITATIONS

- A. These procedures are not considered prophylactic for osteoporosis of the spine or for chronic back pain of long-standing duration, even if associated with old compression fractures.
- B. Neurologic symptoms related to compression or radiculopathy.
- C. Not to be used to treat pain that has shown progressive improvement with non-invasive measures.
- D. If vertebroplasty is being performed to the sacral region (sacroplasty), this is a non-covered service even when billed with a covered code (ex. 22511).

BILLING/ CODING/PHYSICIAN DOCUMENTATION INFORMATION

This policy may apply to the following codes. Inclusion of a code in the section does not guarantee reimbursement.

Applicable codes:

Vertebroplasty Codes: 22510; 22511; 22512; 22513; 22514; 22515; 22899

The Plan may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

References:

1. Medicare Local Coverage Determination for Vertebroplasty/Vertebral Augmentation (L33473) – Palmetto GBA Part A/B; Effective date: 10/01/2015; Accessed via www.cms.gov, 10/9/19.
2. Medicare Local Coverage Determination for Vertebroplasty, Vertebral Augmentation including cavity creation (L34592) – Wisconsin Physicians Service; Effective date: 02/01/2016. Accessed via www.cms.gov 5/16/18.
3. Medicare Local Coverage Determination for Percutaneous Vertebral Augmentation (PVA) for Osteoporotic Vertebral Compression Fracture (VCF) (L38213)-
4. BCBSNC Corporate Medical Policy “Vertebroplasty and Kyphoplasty, Percutaneous “Effective date 8/2010; Accessed online at <http://www.bcbsnc.com/content/providers/medical-policies-and-coverage/index.htm>; Viewed on 10/8/19.

Policy Implementation/Update Information:

Revision Date: 8/20/03 Policy renamed to Vertebroplasty and Kyphoplasty, Percutaneous, 8/2003. Previous policy name “Vertebroplasty Percutaneous-Medicare + Choice.”

Revision Date: September 2009: Code review only.

Revision Date: 1/05/11 Policy renamed to Vertebroplasty and Percutaneous Vertebral Augmentation, per new CMS policy.

- Description of Procedure/Service section: Updated with current CMS language. Replaced Kyphoplasty with Percutaneous Vertebral Augmentation.
- Indications for Coverage section: For Vertebroplasty Coverage: Bullets 3 and 5 pertaining to retired policies and Contraindications section were removed. First two bullet items added from LCD L31344. For Percutaneous Vertebral Augmentation: Updated language from new policy, bullet 3 pertaining to retired policies removed, and added bullet 1, from new policy.
- When Coverage Will Not Be Approved section: Removed this section and associated language pertaining to retired LCD L22552 and replaced with the Contraindications section from LCD L31344 and L17864 for clarity.
- Reference section: New CMS policy added and retired policies L22552 and L9710 removed.
- Limitations: Added this section and language to policy to mirror new CMS policy.

Revision Date: 03/15/2013: Annual review; Reformatted and to mirror NCD.

Revision Date: 08/20/2014: This policy was revised to eliminate the time frame for conservative therapy for criteria B.2. Also, multidisciplinary was deleted regarding the decision for treatment. No changes in LCD or NCD noted.

Revision Date: 1/21/15; Updated codes and added to policy; no other revisions required. October 29, 2015 updated LCD due to ICD-10 update only.

Revision Date: 9/21/2016: Policy Revised by removing Sub point (A) from the Limitations Section to reflect changes on the updated LCD (L33473). No other changes. Minor revisions only.

Revision Date: 5/16/18; Annual Review. No CMS Updates. Minor Revisions Only.

Revision Date: 10/16/19; Staff Clarification; Added: Limitations Section: D. If vertebroplasty is being performed to the sacral region (sacroplasty), this is a non-covered service even when billed with a covered code (ex. 22511).

Revision Date: 6/17/20; Annual Review; CMS Updates to LCD. Minor revisions only. Criteria still current with Part B LCD.

Approval Dates:

Medical Coverage Policy Committee: June 17, 2020

Policy Owner: Carolyn Wisecarver, RN, BSN
Medical Policy Coordinator