



CLINICAL GUIDELINES

CMM-607: Primary Vertebral Augmentation (Percutaneous Vertebroplasty/Kyphoplasty) and Sacroplasty Guidelines

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eviCore healthcare Clinical Decision Support Tool Diagnostic Strategies: This tool addresses common symptoms and symptom complexes. Requests for individuals with atypical symptoms or clinical presentations that are not specifically addressed will require physician review. Consultation with the referring physician, specialist and/or individual's Primary Care Physician (PCP) may provide additional insight.

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Clinical guidelines for medical necessity review of Comprehensive Musculoskeletal Management Services.

CMM-607: Primary Vertebral Augmentation (Percutaneous Vertebroplasty/Kyphoplasty) and Sacroplasty

CMM-607.1: General Guidelines	3
CMM-607.2: Indications	3
CMM-607.3: Non-Indications	4
CMM-607.4: Procedure (CPT®) Codes	5
CMM-607.5: References	6

CMM-607.1: General Guidelines

- The determination of medical necessity for the performance of vertebral augmentation (percutaneous vertebroplasty/kyphoplasty) and sacroplasty is always made on a case-by-case basis.
- For prior authorization requirements, see **CMM-600.1: Prior Authorization Requirements**.
- The presence of urgent/emergent indications/conditions warrants definitive surgical treatment. Confirmatory advanced imaging studies are required. The following criteria are **NOT** required for confirmed urgent/emergent conditions:
 - ◆ Provider-directed non-surgical management
- Urgent/emergent conditions for vertebral augmentation procedure include **EITHER** of the following:
 - ◆ Primary or metastatic neoplastic disease causing pathologic fracture
 - ◆ Documentation of severe debilitating pain and/or dysfunction to the point of being incapacitated

CMM-607.2: Indications

Vertebral augmentation (injection of methylmethacrylate cement under imaging guidance) is considered **medically necessary** when **ALL** of the following are met:

- Performed for **ANY** of the following conditions which is concordant with recent (within 6 months) confirmatory imaging:
 - ◆ Osteolytic or osteoporotic vertebral compression fracture with persistent and debilitating pain
 - ◆ Osteolytic metastases including destruction of a vertebral body by multiple myeloma
 - ◆ Primary malignant neoplasm of bone or bone marrow
 - ◆ Painful and/or aggressive space occupying lesions of a vertebral body (hemangioma/eosinophilic granuloma)
 - ◆ Pre-surgical stabilization of a vertebral body to facilitate a fusion operation
 - ◆ Painful osteonecrotic (i.e., Kummel disease) vertebral compression fracture
 - ◆ Steroid induced vertebral compression fracture
- Persistent debilitating pain including **BOTH** of the following:
 - ◆ Significant level of pain on a daily basis defined as **EITHER** of the following:
 - Visual Analog Scale (VAS)/Number Rating Scale (NRS) ≥ 7
 - Severe, disabling, crippling, or incapacitating pain
 - ◆ Clinically significant functional impairment (e.g. inability to perform household chores, prolonged standing or essential job functions)

- **EITHER** of the following:
 - ◆ Acute (0-6 weeks) axial back pain that persists at a level which prevents independent transfers and/or ambulation and correlates with the level of the fracture
 - ◆ Subacute (> 6 weeks) axial pain in the thoracic/lumbar spine for at least 4 weeks including the following:
 - Less than clinically meaningful improvement with **BOTH** of the following (unless contraindicated):
 - Prescription strength analgesics, steroids, and/or NSAIDs for 4 weeks
 - Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 4 weeks
- Performed at no more than 2 levels of the T5-L5 spine on the same date of service

CMM-607.3: Non-Indications

Not medically Necessary

- Vertebral Augmentation (Percutaneous Vertebroplasty/Kyphoplasty) is considered **not medically necessary** for **EITHER** of the following:
- The presence of ANY of the following contraindications:
 - ◆ Allergy to materials used in the procedure
 - ◆ Uncorrected coagulation disorders or anticoagulation therapy
 - ◆ Myelopathy associated with a bone fragment in the spinal canal or cord compression from a tumor
 - ◆ Extensive vertebral destruction
 - ◆ Burst fracture associated with widened pedicles and/or retropulsed bone fragments
 - ◆ Potential space occupying lesions causing cord compression (tumor, bone fragment)
 - ◆ Collapse of vertebral body to less than the level of the vertebra plana
 - ◆ The use of Norian XR cement and Norian SRS cement products is prohibited because they are not FDA approved
 - ◆ Radiculopathy from a herniated intervertebral disc
 - ◆ Untreated symptomatic foraminal or canal stenosis, facet arthropathy, or other significant coexistent spinal or bony pain generators
 - ◆ Unstable fracture or requirement for stabilization procedure in the same or adjacent spinal region
 - ◆ Septicemia and any active infection (including urinary tract infection [UTI])
 - ◆ Active osteomyelitis of the target vertebra
 - ◆ Severe cardiopulmonary disease
 - ◆ Lack of credentialed spine surgeon to perform an urgent laminectomy in the event of cement extravasation into the spinal canal
- The presence of **ANY** of the following alternative causes of axial back pain:
 - ◆ Lumbar/thoracic radiculopathy or facet disease
 - ◆ Lumbar/thoracic/sacral trigger points
 - ◆ Sacral insufficiency fractures

Experimental, Investigational, and/or Unproven (EIU)

- Primary Vertebral Augmentation (Percutaneous Vertebroplasty/Kyphoplasty) is considered **experimental, investigational, or unproven (EIU)** for **EITHER** of the following:
 - ◆ Percutaneous vertebral augmentation for **ANY** of the following:
 - Non-painful/non-aggressive vertebral hemangioma
 - Vertebrae of the cervical spine and thoracic levels T1-T4
 - Stabilization of insufficiency fractures or lesions of the sacrum (sacroplasty) or coccyx (coccygeoplasty)
 - Prophylactic treatment for osteoporosis of the spine
 - Prophylactic treatment for chronic back pain of longstanding duration (>6 months), even if associated with old compression fracture(s)
 - ◆ Spinoplasty (e.g. OptiMesh® 1500E Polyethylene Terephthalate (PET) mesh pouch)

CMM-607.4: Procedure (CPT®) Codes

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code's inclusion on this list does not necessarily indicate prior authorization is required.	
CPT®	Code Description/Definitions
22510	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic
22511	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral
+22512	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure)
22513	Percutaneous Vertebral Augmentation, Including Cavity Creation (Fracture Reduction and Bone Biopsy Included When Performed) Using Mechanical Device, (e.g. Kyphoplasty); 1 Vertebral Body, Unilateral or Bilateral Cannulation, Inclusive Of All Imaging Guidance; Thoracic
22514	Percutaneous Vertebral Augmentation, Including Cavity Creation (Fracture Reduction and Bone Biopsy Included When Performed) Using Mechanical Device, (e.g. Kyphoplasty); 1 Vertebral Body, Unilateral or Bilateral Cannulation, Inclusive Of All Imaging Guidance; Lumbar
+22515	Percutaneous Vertebral Augmentation, Including Cavity Creation (Fracture Reduction and Bone Biopsy Included When Performed) Using Mechanical Device, (e.g. Kyphoplasty); 1 Vertebral Body, Unilateral or Bilateral Cannulation, Inclusive Of All Imaging Guidance; Each Additional Thoracic or Lumbar Vertebral Body (List Separately in Addition to Code for Primary Procedure)
This list may not be all inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the health plan and is based on the individual's policy or benefit entitlement structure as well as claims processing rules.	

CMM-607.5: References

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