

## Percutaneous Vertebroplasty and Kyphoplasty

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These services may or may not be covered by all HealthPartners plans. Please see your plan documents for your own coverage information. If there is a difference between this general information and your plan documents, your plan documents will be used to determine your coverage.

### Administrative Process

Does not require prior approval.

### Coverage

Percutaneous vertebroplasty and kyphoplasty are covered subject to the indications listed below.

### Indications that are covered

**Percutaneous vertebroplasty** when one or more of the following conditions exist:

1. Osteoporotic compression fractures/collapse with debilitating pain, which has not responded to standard medical treatment.
2. Osteolytic metastasis with severe back pain related to a destruction of the vertebral body;
3. Multiple Myeloma with severe back pain related to a destruction of the vertebral body;
4. Painful and/or aggressive hemangioma (or eosinophilic granulomas of the spine);
5. Painful vertebral fracture associated with osteonecrosis (Kummell Disease);
6. Reinforcement, or stabilization, of vertebral body prior to surgery: and

AND

When all of the following criteria are present:

1. Severe debilitating pain or loss of mobility that cannot be relieved by standard medical therapy, and
2. Other causes of pain have been ruled out with appropriate diagnostic tests (e.g.: ruled out herniated intervertebral disk with advanced radiologic scans such as CT or MRI), and
3. The affected vertebra has not been widely destroyed and is at least one third of its original height.

**Kyphoplasty** for one of the following conditions:

1. A "recent" osteoporotic compression fracture of the lumbar or thoracic vertebrae with persistent debilitating pain that has not responded to accepted standard medical treatment; and
2. Osteolytic vertebral collapse secondary to multiple myeloma or osteolytic metastatic disease causing persisting or progressive pain.

### Indications that are not covered

Percutaneous vertebroplasty or kyphoplasty are not covered for conditions and criteria other than those described above.

### Definitions

**Percutaneous vertebroplasty** is a procedure for the treatment of a partially collapsed vertebra (backbone) in an effort to relieve pain and provide stability. For the procedure, acrylic bone cement is injected into the affected spinal bone using local anesthesia and light sedation.

**Kyphoplasty** is a minimally-invasive orthopedic procedure used to reduce and stabilize painful vertebral compression fractures (VCF) secondary to osteoporosis. Kyphoplasty cannot correct an established deformity of the spine.

It involves the insertion of one or two balloon devices into the fractured vertebral body. Once inserted, the surgeon inflates the balloon(s) to create a cavity and to compact the deteriorated bone with the intent to restore vertebral

height. The balloon(s) is then removed and the newly created cavity is filled with the surgeon's choice of bone filler material, creating an internal cast for the fractured area.

### Codes (list may not be all inclusive)

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- 22520 - Percutaneous vertebroplasty, 1 vertebral body, unilateral or bilateral injection; thoracic
- 22521 - Percutaneous vertebroplasty, 1 vertebral body, unilateral or bilateral injection; lumbar
- 22522 - Percutaneous vertebroplasty, 1 vertebral body, unilateral or bilateral injection; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)
- 22523 - Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic
- 22524 - Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); lumbar
- 22525 - Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); 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 - Radiological supervision and interpretation, percutaneous vertebroplasty or vertebral augmentation including cavity creation, per vertebral body; under CT guidance

### Products

This information is for most, but not all, HealthPartners plans. Please read your plan documents to see if your plan has limits or will not cover some items. If there is a difference between this general information and your plan documents, your plan documents will be used to determine your coverage. These coverage criteria may not apply to Medicare Products if Medicare requires different coverage. For more information regarding Medicare coverage criteria or for a copy of a Medicare coverage policy, contact Member Services at 952-883-7979 or 1-800-233-9645.

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