

Percutaneous Vertebroplasty and Kyphoplasty

Administrative Process

Does not require prior approval.

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.

Coverage

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

CPT codes: Percutaneous vertebroplasty - 22520 Kyphoplasty 22523, 22524, 22525; Fluoroscopy – 76012

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.

Products

Consult your plan documents (Membership Contract, Summary Plan Description [SPD], Evidence of coverage [EOC] or similar plan document) to determine governing contractual provisions, including exclusions and limitations relating to your specific plan. These guidelines apply to most, but not all, plans offered by HealthPartners. We strive to ensure that the contents of this site are correct and complete, but to verify your benefits, please check your contract or SPD, or contact Member Services. In the event of a conflict between your specific plan documents and this general information, the plan documents will govern. 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 800-233-9645.

Number: P043-03; Approved Medical Director Committee 10/17/00; Revised 8/2/05, 12/5/05 (codes); Annual Review 8/2/05, 6/1/06, 8/1/07.