



## Kyphoplasty and Vertebroplasty

### I. Policy

University Health Alliance (UHA) will reimburse for kyphoplasty and vertebroplasty when it is determined to be medically necessary and when it meets the medical criteria guidelines (subject to limitations and exclusions) indicated below.

### II. Criteria/Guidelines

- A. Percutaneous kyphoplasty, or vertebroplasty is covered (subject to Limitations/Exclusions and Administrative Guidelines) when the following criteria are met:
  1. The patient has acute vertebral compression fractures secondary to osteoporosis, has experienced severe back pain for at least six weeks, and has failed an optimal and genuine trial of conservative therapy that includes, but is not limited to:
    - a. Initial bed rest with progressive activity;
    - b. Physical Therapy and/or;
    - c. Analgesics
  2. The patient has osteolytic vertebral lesions (i.e., metastases or myeloma) with severe back pain related to a destruction of the vertebral body and the patient does not have disseminated visceral metastasis or comorbidities to result in very limited life expectancy;
    - a. Vertebroplasty/kyphoplasty is generally reserved for patients with symptomatic osteolytic spinal metastases, with intact bone cortex and without epidural disease, spinal cord compression, or retropulsion of bone fragments into the spinal cord.
  3. All patients with osteoporosis receiving vertebral augmentation must be treated medically for osteoporosis to prevent additional fractures.
  4. Evaluation by a spinal or physical medicine specialist has been performed.

#### **NOTE:**

*This UHA payment policy is a guide to coverage, the need for prior authorization and other administrative directives. It is not meant to provide instruction in the practice of medicine, and it should not deter a provider from expressing his/her judgment.*

*Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply, and this policy is not a guarantee of payment. UHA reserves the right to apply this payment policy to all UHA companies and subsidiaries.*

*UHA understands that opinions about and approaches to clinical problems may vary. Questions concerning medical necessity (see Hawaii Revised Statutes §432E-1.4) are welcome. A provider may request that UHA reconsider the application of the medical necessity criteria in light of any supporting documentation.*

### III. Limitations/Exclusions

- A. Kyphoplasty will not be covered for more than three vertebral bodies in a single operative session.
- B. Kyphoplasty is contraindicated for compression fractures that are more than one year old.

- C. Kyphoplasty is not to be performed as prophylaxis for either osteoporosis of the spine or chronic back pain if associated with old, healed compression fracture(s).
- D. Because of safety concerns, kyphoplasty/vertebroplasty is contraindicated for patients with the following conditions:
  - 1. Uncorrected coagulation disorders;
  - 2. Underlying infection (e.g., osteomyelitis of the involved vertebra);
  - 3. Severe cardiopulmonary disease;
  - 4. Neurological symptoms related to spinal compression;
  - 5. Allergy to any component required for the procedure;
  - 6. Consideration must be given to the extent of the disease, the spinal level involved, and previous treatments attempted before considering kyphoplasty/vertebroplasty as an option;
  - 7. In situations when a patient's condition makes the procedure unsafe, or if there will be limited or no significant improvement in activities of daily living, kyphoplasty/vertebroplasty will not be eligible for payment.
- E. Patient selection is a critical factor for both the decision to perform vertebral augmentation and for the selection of the type of procedure. For patients with mild to moderate pain that is responding to medical management, vertebral augmentation is not indicated. Nuances related to age, functional status, and the preservation of height are important considerations.

#### **IV. Administrative Guidelines**

- A. Prior authorization is required.
- B. To request prior authorization, please submit via UHA's online portal. If a login has not been established, you may contact UHA at 808-532-4000 to establish one.
- C. The following documentation should be included with the prior authorization request:
  - 1. Documentation showing a high degree of certainty through targeted physical exam and ancillary studies such as x-ray, bone scan, and MRI that the pain is caused by a non-healing fracture.
    - a. Documentation of imaging reports (i.e., x-rays, CT, MRI studies)
    - b. Documentation of bone scan or MRI, if indicated (i.e., if the age of the fracture(s) is indeterminate)
  - 2. An ancillary study confirms that the pain is not caused by the presence of a spinal or disc fragment.
  - 3. The vertebral body height is not less than one-third of its original height.
- D. CPT code 20225 for a bone biopsy is considered incidental to the kyphoplasty/vertebroplasty procedure and is not payable separately.

<b>CPT Codes</b>	<b>Description</b>
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)

#### **V. Policy History**

**Policy Number:** MPP-0061-120301

**Current Effective Date:** 08/01/2022

**Original Document Effective Date:** 03/01/2012

**Previous Revision Dates:** 03/19/2018, 03/01/2019, 08/08/2019

**PAC Approved Date:** 03/01/2012