Sentara Health Plans

Commercial

Percutaneous Spinal Augmentation, Surgical 231

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Effective Date	10/1/2026
Next Review Date	6/2027
Coverage Policy	Surgical 231
Version	6

Member-specific benefits take precedence over medical policy and benefits may vary across plans. Refer to the individual's benefit plan for details *.

Description & Definitions:

Percutaneous vertebral augmentation procedures include vertebroplasty, balloon kyphoplasty, ~~and~~ mechanical kyphoplasty and sacroplasty.

Balloon kyphoplasty inserts and inflates a balloon inside the compressed vertebral body prior to cement injection to restore the normal height of the vertebral body.

Mechanical kyphoplasty uses a device other than a balloon to expand the collapsed vertebral body.

Sacroplasty injects bone cement or similar material through the skin and into the sacrum to form a permanent bond.

Vertebroplasty uses imaged-guided injection(s) of bone cement, typically polymethylmethacrylate.

Other common names: PVA, Percutaneous polymethylmethacrylate vertebroplasty (PPV), kyphoplasty, SpineJack System, StabiliT® Vertebral Augmentation System, Kiva® VCF System (PolyEtherEtherKetone (PEEK) implant), Vertebral Body Stenting

Criteria:

Percutaneous Spinal Augmentation (Vertebroplasty, Kyphoplasty) in cervical, thoracic, lumbar and sacral vertebrae may be considered medically necessary for **1 or more** of the following :

- **Vertebroplasty or balloon kyphoplasty** or mechanical vertebral augmentation with **ALL** of the following:
  - Individual with severe, debilitating pain due to vertebral compression fractures from **1 or more** of the following:
    - Aggressive hemangiomas causing severe pain or nerve compression and refractory to radiation therapy
    - Osteolytic lesions of the spine due to multiple myeloma, plasmacytoma or metastatic malignancies refractory to chemotherapyand/or radiation therapy
    - Primary malignant cancers of bone
    - Steroid-induced vertebral compression fracture
    - Symptomatic osteoporotic vertebral fractures for **1 or more** of the following:

- Present for at least 6 weeks and have failed to respond to conservative treatment (e.g. include initial bed rest withprogressive activity, analgesics, physical therapy, bracing, graded exercises to improve muscle tone and correct posturaldeformity, medications such as calcitonin, bisphosphonates and calcium supplementation)
- Present for less than 6 weeks but interfering with ambulation and requiring hospitalization for pain control
- Unstable, osteonecrotic (i.e., Kummell disease) vertebral compression fractures
- Vertebral eosinophilic granuloma causing spinal instability

- Imaging (x-ay, CT scan, MRI) shows **ALL** of the following:
  - The fracture is recent (less than 4 months old)
  - The affected vertebra is at least 1/3 of its original height
  - The affected vertebra is not already healed
  - Rules out other causes of back pain (e.g. herniated intervertebral disk, degenerative disc disease, facet arthropathy, foraminalstenosis, spinal
- Not more than 3 levels performed at once.

- **Sacroplasty** may be considered medically necessary with ~~for~~ **ALL** of the following:
  - Osteoporotic sacral fracture(s)
  - Treatment of acute (< 6 weeks) or subacute (6 to 12 weeks) sacral fractures
  - Confirmed by recent (within 30 days) advanced imaging (bone marrow edema on MRI or bone-scan/SPECT/CT uptake)
  - has not responded to conservative treatment, which may have included NSAIDs, opioid medications, physical therapy, and/or rest.

Percutaneous Spinal Augmentation (Vertebroplasty, Kyphoplasty) are considered **not medically necessary** or contraindicated for any use other than those indicated in clinical criteria, to include but not limited to:

- Allergy to bone cement or opacification agents
- Current back pain not primarily due to identified acute or subacute VCF(s)
- Fracture retropulsion/canal compromise
- Greater than 3 vertebral fractures per procedure
- Individual with existing uncorrected coagulopathy or anticoagulation therapy
- Individual with known allergy to any materials used in procedure, such as contrast media or bone cement
- Kyphoplasty for individual when vertebral body fracture is associated with widened pedicles or retropulsion of bone as in a burst fracture
- Kyphoplasty for individual with fracture caused by high-velocity injury or other causes of disabling back pain not due to acute fracture
- Neural impingement
- Neurologic deficit
- Osteomyelitis, discitis, active systemic infection, or surgical site infection
- Pain that has shown progressive improvement with non-invasive measures
- Pregnancy
- Retropulsed bone fragments resulting in spinal canal compromise and myopathy
- Spinal canal compromise secondary to tumor resulting in myelopathy
- Spinal instability
- Vesselplasty

Document History:

Revised Dates:

- 2026: June – Implementation date of October 1, 2026. Annual review and Housekeeping. No change in criteria.
- 2025: July – Implementation date of October 1, 2025. Full review. Housekeeping and New format. No changes to criteria
- 2024: July- Added not more than 3 levels performed at once to criteria

- 2023: July
- 2022: July
- 2020: August
- 2016: April
- 2015: February, May, September
- 2014: January, June, August, November
- 2013: May, June
- 2012: February, May
- 2011: May, June, November
- 2010: May
- 2009: May
- 2008: May
- 2006: October
- 2004: September
- 2002: August

Reviewed Dates:

- 2019: April
- 2018: November
- 2017: December
- 2016: May
- 2014: May
- 2010: April
- 2007: December
- 2005: February, October
- 2004: July
- 2003: July

Origination Date: May 2002

Coding:

Medically necessary with criteria:

Coding	Description
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 (eg, 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 (eg, 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 (eg, 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)
0200T	Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used, 1 or more needles, includes imaging guidance and bone biopsy, when performed
0201T	Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, 2 or more needles, includes imaging guidance and bone biopsy, when performed

Considered Not Medically Necessary:

Coding	Description
	None

U.S. Food and Drug Administration (FDA) - approved only products only.

The preceding codes are included above for informational purposes only and may not be all inclusive. Additionally, inclusion or exclusion of a treatment, procedure, or device code(s) does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Special Notes: *

- Coverage:
  - See the appropriate benefit document for specific coverage determination. Member specific benefits take precedence over medical policy.
- Application to products:
  - Policy is applicable to Sentra Health Plan Commercial products.
- Authorization requirements:
  - Pre-certification by the Plan is required.
  - **Please refer to Prior Authorization List for most up to date requirement Search PAL List: Sentara Health Plans**
- Special Notes:
  - Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving, and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.
  - Services mean both medical and behavioral health (mental health) services and supplies unless We specifically tell You otherwise. We do not cover any services that are not listed in the Covered

Services section unless required to be covered under state or federal laws and regulations. We do not cover any services that are not Medically Necessary. We sometimes give examples of specific services that are not covered but that does not mean that other similar services are covered. Some services are covered only if We authorize them. When We say You or Your We mean You and any of Your family members covered under the Plan. Call Member Services if You have questions.

References:

Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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Keywords:

Percutaneous Spinal Augmentation, SHP Surgical 231, Percutaneous vertebroplasty, balloon kyphoplasty, compression fractures, osteoporotic vertebral fractures, Osteolytic lesions, Percutaneous sacroplasty, PVA, Percutaneous polymethylmethacrylate vertebroplasty (PPV), kyphoplasty, SpineJack System, StabiliT® Vertebral Augmentation System, Kiva® VCF System (PolyEtherEtherKetone (PEEK) implant), Vertebral Body Stenting, VA