Sentara Health Plans

Medicaid

Percutaneous Spinal Augmentation, Surgical 231

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Coverage Policy	Surgical 231
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All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*.

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
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

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.

Policy Approach and 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 Sentara Health Plan Virginia Medicaid Products
- Authorization requirements
  - Precertification required by Plan
- Special Notes:
  - This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.
  - 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.
  - The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. EPSDT Supplement B (updated 5.19.22)_Final.pdf
  - Service authorization requests must be accompanied by sufficient clinical records to support the request. Clinical records must be signed and dated by the requesting provider withing 60 days of the date of service requested.

References:

References used include but are not limited to the following: 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