

Medicare (WPS) Summary

Local Coverage Determination (LCD) for Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF)¹

Effective date: 9/1/22

Percutaneous vertebroplasty and percutaneous vertebral augmentation (PVA or kyphoplasty) procedures will be considered **medically reasonable and necessary** for the following:

Inclusion criteria (ALL are required)

1. Painful, debilitating, osteoporotic vertebral collapse/compression fractures, that have not responded to non-surgical management (e.g. narcotic and/or non-narcotic medication, physical therapy modalities) with or without methods of immobility (e.g. bed rest, bracing).

- Acute (<6 weeks) or subacute (6-12 weeks) osteoporotic VCF (T1-L5) based on symptom onset, and documented by recent (within 30 days) advanced imaging (bone marrow edema on MRI or bone-scan/SPECT/CT uptake) and
- The beneficiary is symptomatic and is hospitalized with severe pain (Numeric Rating Scale [NRS] or Visual Analog Scale [VAS] pain score ≥ 8) or is non-hospitalized with moderate to severe pain (NRS or VAS ≥ 5) despite optimal non-surgical management (NSM) with one of the following:
 - Worsening pain or
 - Stable to improved pain (but NRS or VAS still ≥ 5) when 2 or more of the following are present:
 - ✓ Progression of vertebral body height loss
 - ✓ >25% vertebral body height reduction
 - ✓ Kyphotic deformity
 - ✓ Severe impact of VCF on daily functioning (Roland Morris Disability Questionnaire (RDO) > 17)
 - ✓ Steroid-induced fractures
 - ✓ Reinforcement of stabilization of vertebral body prior to surgery

Continuum of care

- ▶ All patients presenting with vertebral compression fractures (VCF) should be referred for evaluation of bone mineral density and osteoporosis education for subsequent treatment as indicated and instructed to take part in an osteoporosis prevention/treatment program.

2. Osteolytic vertebral metastasis or myeloma with severe back pain related to a destruction of the vertebral body, not involving the major part of the cortical bone.

- ▶ Painful osteolytic metastasis
- ▶ Multiple myeloma with painful vertebral body involvement

3. Trauma, even minor falls, can produce a spine fracture. Many of these injuries will never require surgery, but major fractures can result in serious long-term problems unless treated promptly and properly. These severe injuries frequently result in spinal instability, with a high risk of spinal cord injury and pain, which can produce a spine fracture. WPS is reinstating coverage of PVA as reasonable and necessary for the following traumatic conditions

- ▶ Stable and/or unstable burst fractures
- ▶ Wedge compression fractures
- ▶ Fracture-dislocations that occur following auto accidents or falls from height

Exclusion criteria (can have NONE of the following)

Absolute contraindication

- Current back pain is not primarily due to the identified acute VCF(s)
- Osteomyelitis, discitis or active systemic infection

Relative contraindication

- Greater than three vertebral fractures per procedure
- Allergy to bone cement or opacification agents
- Uncorrected coagulopathy
- Spinal instability
- Myelopathy from the fracture
- Neurologic deficit
- Neural impingement
- Fracture retropulsion/canal compromise
- Pregnancy

Billing and coding: PVA for VCF²**CPT codes³**

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)

ICD-10-CM⁴ diagnosis codes that support medical necessity*Group 1*

M80.08XA Age-related osteoporosis with current pathological fracture, vertebra(e), initial encounter for fracture

M80.08XS Age related osteoporosis with current pathological fracture, vertebra(e), sequela

M80.88XA Other osteoporosis with current pathological fracture, vertebra(e), initial encounter for fracture

M80.88XS Other osteoporosis with current pathological fracture, vertebra(e), sequela

Group 2

C41.2* Malignant neoplasm of vertebral column

C79.51* Secondary malignant neoplasm of bone

C79.52* Secondary malignant neoplasm of bone marrow

C90.00* Multiple myeloma now having achieved remission

C90.01* Multiple myeloma in remission

C90.02* Multiple myeloma in relapse

C96.5 Multifocal and unisystemic Langerhans-cell histiocytosis

C96.6 Unifocal Langerhans-cell histiocytosis

C96.A Histiocytic sarcoma

D16.6 Benign neoplasm of vertebral column

D47.1 Chronic myeloproliferative disease

E24.0 Pituitary-dependent Cushing's disease

E24.1 Nelson's syndrome

E24.2 Drug-induced Cushing's syndrome

E24.3 Ectopic ACTH syndrome

E24.4 Alcohol-induced pseudo-Cushing's syndrome

E24.8 Other Cushing's syndrome

E24.9 Cushing's syndrome, unspecified

M81.6 Localized osteoporosis [Lequesne]

T38.0X5A Adverse effect of glucocorticoids and synthetic analogues, initial encounter

T38.0X5D Adverse effect of glucocorticoids and synthetic analogues, subsequent encounter

T38.0X5S Adverse effect of glucocorticoids and synthetic analogues, sequela

Group 3

M84.58XA Pathological fracture in neoplastic disease, other specified site, initial encounter for fracture

M84.58XD Pathological fracture in neoplastic disease, other specified site, subsequent encounter for fracture with routine healing

M84.58XG Pathological fracture in neoplastic disease, other specified site, subsequent encounter for fracture with delayed healing

M84.58XK Pathological fracture in neoplastic disease, other specified site, subsequent encounter for fracture with nonunion

M84.58XP Pathological fracture in neoplastic disease, other specified site, subsequent encounter for fracture with malunion

M84.58XS Pathological fracture in neoplastic disease, other specified site, sequela

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Codes with an * require a dual diagnosis. Requires one from Group 1 and one from Group 3

Sources:

1. WPS Final Effective LCD (L38213). Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF). Available on CMS website. Retrieved 3/14/23.
2. WPS Billing and Coding Article (A57630). Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF). Available on CMS website. Retrieved 3/14/23.
3. Current Procedural Terminology 2022, American Medical Association. Chicago, IL 2022. CPT is a registered trademark of the American Medical Association. Current Procedural Terminology (CPT®) is copyright 2022 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
4. International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) (available on CMS website).

Interventional Spine

A healthcare professional must always rely on his or her own professional clinical judgment when deciding the treatment for a particular patient. Stryker does not dispense medical advice and does not recommend any specific protocol or treatment regimen.

The information presented is for information and illustrative purposes. The provider is solely responsible for reporting the codes that accurately describe the services furnished to a particular patient as well as the patient's medical condition. Providers are responsible for their decisions relating to coding, medical necessity and reimbursement submissions. It is the provider's responsibility to determine and document that the services provided are medically necessary. This information does not represent a guarantee of coverage or payment.

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