GUIDELINES
This policy does not certify benefits or authorization of benefits, which is designated by each individual policyholder contract. Paramount applies coding edits to all medical claims through coding logic software to evaluate the accuracy and adherence to accepted national standards. This guideline is solely for explaining correct procedure reporting and does not imply coverage and reimbursement.

DESCRIPTION
Percutaneous Vertebroplasty
Percutaneous vertebroplasty is a radiologic technique involving fluoroscopic-guided injection of polymethylmethacrylate (PMMA) through a needle inserted into a weakened vertebral body. This technique has been used in patients with osteolytic metastases and multiple myeloma, as a method of relieving pain and improving bone strength. It has also been investigated as a therapy for vertebral collapse related to osteoporosis, or as treatment of a painful vertebral hemangioma. This technique has been used in all levels of the vertebrae including the cervical, thoracic, and lumbar spine. Percutaneous vertebroplasty is performed by a one or two-sided injection of the vertebral body. Imaging techniques such as fluoroscopy is used to guide needle placement and monitor the injection procedure. Cement is used to reinforce the damaged or collapsed vertebra stabilizing the bone.

Percutaneous Kyphoplasty
Percutaneous kyphoplasty is a variation of percutaneous vertebroplasty. Under fluoroscopic guidance, an inflatable balloon is inserted to expand a collapsed vertebral body to its natural height before injection of polymethylmethacrylate (PMMA). The PMMA is injected through a needle inserted into the weakened vertebral body. Often a bone biopsy is performed at the same spinal level. This service can be performed on the thoracic and lumbar spinal levels.

Percutaneous kyphoplasty is usually performed on patients with vertebral collapse with persistent debilitating pain, which has not responded to standard medical treatment. This has also been used on patients with osteolytic metastases and multiple myeloma, as a method of improving bone strength and relieving pain. It is also used to relieve pain related to osteoporosis or in the treatment of painful vertebral hemangioma. During this procedure, alignment is restored and the bone cement is injected to stabilize the spine.

Percutaneous Sacroplasty
Sacroplasty, a variation of vertebroplasty, is an evolving technique that has been proposed for the treatment of sacral insufficiency fractures. Percutaneous sacroplasty continues to be studied as an alternate treatment for osteoporotic sacral in-sufficiency. There is insufficient evidence in the published medical literature to demonstrate the safety, efficacy, and long-term outcomes of this procedure.

POLICY
- Percutaneous vertebroplasty (22510, 22511, 22512) and percutaneous kyphoplasty (22513, 22514, 22515) do not require prior authorization.
- Cervical percutaneous vertebroplasty (S2360, S2361) is non-covered.
- Percutaneous Sacroplasty (0200T, 0201T) is non-covered.

HMO, PPO, Individual Marketplace, Elite, Advantage
Percutaneous vertebroplasty (22510, 22511, 22512) is considered medically necessary after failure of standard medical therapy when any of the following criteria are met:
- Osteolytic vertebral metastasis and myeloma with severe back pain related to a destruction of the vertebral body, not involving the major part of the cortical bone.
- Vertebral hemangiomas with aggressive clinical signs (severe pain or nervous compression) and/or aggressive radiological signs.
- 2 -

- Osteoporotic vertebral collapse with persistent debilitating pain that has not responded to accepted standard medical treatment appropriate for each patient. Documentation should be available to support the use of PV or PVA early in the treatment regimen.
- Painful vertebral eosinophilic granuloma with spinal instability.
- Steroid-induced vertebral fractures.

Percutaneous kyphoplasty (22513, 22514, 22515) is considered medically necessary after failure of standard medical therapy when any of the following criteria are met:

- Osteolytic vertebral metastasis and myeloma with severe back pain related to a destruction of the vertebral body, not involving the major part of the cortical bone.
- Osteoporotic vertebral collapse with persistent debilitating pain that has not responded to accepted standard medical treatment appropriate for each patient. Documentation should be available to support the use of PV or PVA early in the treatment regimen.

Paramount does not cover percutaneous vertebroplasty or kyphoplasty for any other indication because each is considered experimental, investigational, or unproven.

Cervical percutaneous vertebroplasty (S2360, S2361) is considered investigational and not medically necessary for all indications.

Percutaneous sacroplasty (0200T, 0201T) is considered investigational and not medically necessary for all indications.

**CODING/BILLING INFORMATION**

The appearance of a code in this section does not necessarily indicate coverage. Codes that are covered may have selection criteria that must be met. Payment for supplies may be included in payment for other services rendered.

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**REVISION HISTORY EXPLANATION**

01/01/07: No change
01/01/08: No change
10/01/08: Revised verbiage
06/15/09: Added codes
02/01/11: Updated codes
07/01/12: No change
05/12/15: Removed deleted effective 12/31/14 codes 22520-22525, & 72291-72292. Added new effective 1/1/15 codes 22510-22515. Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee.

REFERENCES/RESOURCES
Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
Ohio Department of Medicaid http://jfs.ohio.gov/
American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services
Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
Industry Standard Review
Hayes, Inc.