blue of california

Medical Policy

Percutaneous Kyphoplasty, Vertebroplasty and Sacroplasty	
Type: Medical Necessity and Investigational / Experimental	**Policy Specific Section:** Surgery
Original Policy Date: February 14, 2001	**Effective Date:** July 13, 2012

Definitions of Decision Determinations

Medically Necessary: A treatment, procedure or drug is medically necessary only when it has been established as safe and effective for the particular symptoms or diagnosis, is not investigational or experimental, is not being provided primarily for the convenience of the patient or the provider, and is provided at the most appropriate level to treat the condition.

Investigational/Experimental: A treatment, procedure or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

Split Evaluation: Blue Shield policy review can result in a Split Evaluation, where a treatment, procedure or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

Description

Percutaneous kyphoplasty, vertebroplasty and sacroplasty are interventional radiology techniques involving the fluoroscopically guided injection of bone cement (e.g., polymethylmethacrylate (PMMA)) through a needle inserted into a weakened vertebral body. These techniques have been investigated as options to provide mechanical support and

symptomatic relief in patients with osteoporotic vertebral compression fracture or in the presence of osteolytic lesions of the spine (e.g., multiple myeloma or metastatic malignancies).

Balloon kyphoplasty is a variant of vertebroplasty that uses a specialized bone tamp with an inflatable balloon to expand a collapsed vertebral body as close as possible to its natural height before injection of the PMMA. Radiofrequency (RF) kyphoplasty is a modification of balloon kyphoplasty using RF to achieve the desired consistency of the cement.

Policy

Percutaneous vertebroplasty and kyphoplasty may be considered **medically necessary** for **any** of the following indications:

- Symptomatic osteoporotic vertebral fractures and failed conservative treatment for at least six weeks (e.g. analgesics, physical therapy and rest).
- Severe pain due to osteolytic lesions of the spine related to multiple myeloma or metastatic malignancies
- Vertebral eosinophilic granuloma with spinal instability
- Vertebral hemangiomas with **all** of the following:
    - Aggressive signs (e.g., myelopathy, radiculopathy, bone fracture, collapse or destruction)
    - Radiation therapy has failed to relieve symptoms

Percutaneous vertebroplasty and/or kyphoplasty are considered **investigational** for all other indications including, but not limited to, treatment of acute vertebral fractures due to osteoporosis or trauma.

Percutaneous sacroplasty is considered **investigational** for all indications including, but not limited to:

- Sacral insufficiency fractures due to osteoporosis
- Spinal lesions due to metastatic malignancies or multiple myeloma

Policy Guideline

The following codes are used for the radiological supervision and interpretation services associated with these procedures:

72291-72292: Radiological supervision and interpretation, percutaneous vertebroplasty or vertebral augmentation including cavity creation, per vertebral body; under fluoroscopic or CT guidance, respectively.

Percutaneous kyphoplasty, vertebroplasty and/or sacroplasty may be performed by interventional radiologists or orthopedic surgeons.

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Internal Information

There is an MD Determination Form for this Medical Policy. It can be found on the following Web page:
http://myworkpath.com/healthcareservices/MedicalOperations/PSR_Determination_Pages.htm

Documentation Required for Clinical Review

• History and physical and/or consultation reports including:
  o Description of conservative treatments attempted, duration, and responses
  o Treatment plan
• Radiology reports (as applicable)
Post Service
• Operative report(s)

The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract. These Policies are subject to change as new information becomes available

Click here to view the appendix for this policy

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