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Local Coverage Determination (LCD): Vertebroplasty, Vertebral Augmentation; Percutaneous (L33500)

Contractor Information

Contractor Name	Contract Number	Contract Type
Noridian Healthcare Solutions, LLC opens in new window	01182	MAC - Part B

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LCD Information

Document Information

LCD ID
L33500

Jurisdiction
California - Southern

LCD Title
Vertebroplasty, Vertebral Augmentation; Percutaneous

Original Effective Date
For services performed on or after 09/16/2013

Revision Effective Date
For services performed on or after 11/01/2013

Revision Ending Date
N/A

Retirement Date
N/A

Notice Period Start Date
N/A

Notice Period End Date
N/A

CMS National Coverage Policy Title XVIII of the Social Security Act, §1862(a)(1)(A). Allows coverage and payment for only those services that are considered to be reasonable and necessary.

Title XVIII of the Social Security Act, §1833(e). Prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual,* Chapter 13, §80.1 Physician Presence

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual,* Chapter 30, §20.2.1 Categorical Denials, §50.1 Introduction - General Information (ABN)

Coverage Guidance
Coverage Indications, Limitations, and/or Medical Necessity

Percutaneous Vertebroplasty:
First described in the literature in 1987 by two French neuroradiologists as a treatment for painful hemangiomas of the spine, Percutaneous Vertebroplasty, also known as PV or PVP, is a therapeutic, interventional radiologic procedure which consists of the injection of a material (usually polymethylmethacrylate) under imaging guidance (either fluoroscopy or CT) into a cervical, thoracic or lumbar vertebral body lesion for the relief of pain and the strengthening of bone.

Several days prior to Vertebroplasty, radiography and computed tomography (CT) or MRI, consistent with the physician's judgment and absent contraindications are performed to assess the extent of vertebral collapse, the location and extent of the lytic or degenerative process, the visibility and degree of involvement of the pedicles, the presence of cortical destruction or fracture and the presence of epidural or foraminal stenosis caused by tumor extension or bone fragment retropulsion.

Percutaneous Vertebroplasty is generally performed as follows:

- With the patient under conscious sedation (not separately billable), the involved vertebra(e) is identified under CT or fluoroscopic control. Patients who experience difficulties with ventilation or who are unable to tolerate the procedure, either due to pain or the prone position necessary to perform the procedure, may require general anesthesia or deep sedation.

- Local anesthesia is applied to the skin and deep structures, including periosteum of the bone at the intended site of entry by the 10-15 gauge bone biopsy or trocar needle. The needle is advanced into the pedicle under CT or biplane fluoroscopic guidance. The latter allows placement of the needle via transpedicular, anterolateral, intercostovertebral or posterolateral approach, depending on the vertebral level and presence of posterior fusion of the vertebrae or pedicular lysis.

- Approximately 2.5 to 8 cc of polymethylmethacrylate (PMMA), which has a useful working time of 5-10 minutes, is injected into the vertebra. Careful monitoring is performed under fluoroscopy during injection to recognize any flow into an undesirable location such as the epidural space or inferior vena cava. It should be noted that this is currently an off-label use of PMMA.

- When vertebral filling is insufficient, a contralateral injection may be performed into the same vertebra. For each vertebral level treated, the procedure time may last for an hour or less. Injection is stopped if a leak of PMMA into the spinal canal and neural foramina.

- Upon completing the injection, the stylet of the needle is replaced and the needle is removed before the PMMA begins to set. Hemostasis at the puncture site is achieved by gentle pressure. More than one vertebra may be treated at the same time depending on the patient's tolerance.

After the procedure, the patient is placed supine and asked to remain flat for 1-3 hours to allow complete curing of the PMMA prior to axial loading. CT may (but is not usually) performed 1-8 hours after PMMA injection to assess its distribution within the vertebral body and to detect leaks into the spinal canal, neural foramina, adjacent intervertebral disks, paravertebral tissue and venous plexus.

Vertebral Augmentation:
Vertebral compression fractures due to osteoporosis represent significant morbidity to a large number of Medicare beneficiaries. It is estimated that perhaps 250,000 individuals out of some 700,000 who suffer from this condition annually fail to respond adequately to conservative, symptom-directed care. This population may represent candidates for vertebral stabilization procedures. Since January 1, 2000 coverage has been allowed for Percutaneous Vertebroplasty.

Emerging literature and clinical experience now support extending our coverage to the procedure known as Vertebral Augmentation. This procedure is similar to Percutaneous Vertebroplasty in that stabilization of the collapsed vertebra is accomplished by the injection of methylmethacrylate cement into the body of the vertebra. The primary difference in the case of Vertebral Augmentation is that the fracture itself is at least partially reduced by augmenting the intrabody space by the use of inflatable balloon, bone tamps or other device by displacing (removing) (compacting) bone to create a space (cavity)(void) prior to the injection of bone void filler (cement) (polymethylmethacrylate) (PMMA). Once the compression is reduced to an acceptable degree, the bone cement is

then injected. In this way, some of the bony deformity and resulting kyphosis may be reduced, often significantly improving the patient's pain. Current literature suggests moderate to good pain relief in 70-90 percent of appropriately selected patients.

The FDA-labeled description of Vertebral Augmentation defines it as entailing a percutaneous approach, and this A/B MAC has valued it accordingly.

Indications and Limitations:

For Percutaneous Vertebroplasty:

- 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;

- Osteoporotic vertebral collapse with persistent debilitating pain which has not responded to accepted standard medical treatment for several weeks;

- Painful vertebral eosinophilic granuloma with spinal instability; and

- Steroid-induced vertebral fractures.

- It is expected that the medical record document that imaging performed correlates with the patient's pain.

For Vertebral Augmentation:

- 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; and

- Osteoporotic vertebral collapse with persistent debilitating pain which has not responded to accepted standard medical treatment.

- This A/B MAC believes it appropriate to continue to limit payment for Vertebral Augmentation to those diagnostic indications which are either part of the FDA labeling or which are supported by appropriate peer -reviewed literature.

For both Vertebroplasty and Vertebral Augmenation, this A/B MAC recognizes that the delay of either treatment pending response to medical management may not be in the best interest of the patient. In those instances where the provider believes it to be medically reasonable and necessary to proceed to treatment with either procedure immediately or within a brief time after the vertebral collapse has occurred, the medical record must clearly document the justification for this decision.

Preoperative diagnostic imaging studies are not the subject of this policy, but are the subjects of other A/B MAC policies.

Provision and billing for the services of an assistant surgeon are not considered reasonable and necessary for either Vertebroplasty or Vertbral Augmentation.

Bone biopsy done at the same level as Vertebral Augmentation is considered to be part of the primary procedure and will not be separately payable. This point is also noted in the current CPT description of codes 22523, 22524, 22525.

Though this policy refers only to "polymethylmethacrylate" and "methylmethacrylate," this A/B MAC would consider the procedure to be payable when utilizing any other material FDA-approved for that purpose.

This A/B MAC has decided to not place any policy limit on the number of levels treated on the same day by either procedure. The medical record must; however, document that treatment of multiple levels meets the requirement of being medically reasonable and necessary.

These procedures are not to be considered prophylactic for osteoporosis of the spine or for chronic back pain of long-standing duration, even if associated with old compression fractures.

Contraindications for both Vertebroplasty and Vetebral Augmentation:

Absolute Contraindications:
Absence of a confirmed acute or subacute fracture;

Symptoms that cannot be related to a fracture;

Radicular symptoms that are explained by bone impinging on nerves or another anatomic lesion;

Unstable fracture;

Asymptomatic vertebral compression fracture;

Active osteomyelitis, whether fungal, bacterial or mybacterial;

Symptomatic spinal stenosis with cauda equina symptoms or signs of cord compression are contraindicated. Burst fracture with retropulsed fragments should be treated with caution.

Uncorrected coagulation disorders; and

Known allergy to any of the materials used in either procedure;

For Vertebral Augmentation, compression fractures shown by the medical record to be more than one year old.

Relative Contraindications for Vertebroplasty:

For Vertebroplasty, significant vertebral collapse (i.e., vertebra reduced to less than one-third of its original height). This condition may render the performance of PV technically difficult to perform and is therefore considered a relative contraindication.

Relative Contraindications for both Vertebroplasty and Vertebral Augmentation :

If either PV or Vertebral Augmentation is performed in a patient with relative contraindication(s), medical record documentation must support the rationale for such a decision.

Reasons for Non-Coverage for both Vertebroplasty and Vertebral Augmentation:

Medicare will deny these procedures as not reasonable and necessary when:

- The medical record does not indicate that conservative medical management - bed rest, bracing, and local or systemic analgesics (e.g., narcotic and/or non-narcotic drugs) - has been tried and failed, ***except as noted above.***

- The service does not follow the guidelines of this A/B MAC; or

- The procedure is performed in a patient with the absolute contraindications as stated above.

Vertebral Augmentation should be billed using CPT 22523, 22524, 22525.

For Vertebral Augmentation, bill one CPT 22523, 22524, 22525 per vertebral body treated, regardless of the number of balloon tamps placed (whether placed unilaterally or bilaterally), then multiple surgery rules will be applied.

Payment for Vertebroplasty (procedure codes 22520, 22521, 22522) and Vertebral Augmentation (22523, 22524, 22525) will be all-inclusive for the entire procedure (i.e., including injection, intraosseous venography, etc.). However, for both Vertebroplasty and Vertebral Augmentation, consistent with the current CPT code descriptors for CPT 72291 and 72292, fluoroscopy or CT may be billed and paid separately for Radiological Supervision and Interpretation as appropriate and according to the CPT instructions, using code 72291 or 72292.

If Vertebral Augmentation is done as an open procedure, such as when done with other open spine procedures, it should be billed with 22899, with a description. Since Vertebral Augmentation is valued as a percutaneous procedure, when a Vertebral Augmentation claim is submitted on the same day as open vertebral procedures, this A/B MAC will presume that the Vertebral Augmentation procedure was done as an open procedure and thus of less complexity than the percutaneous procedure, so will decrease the reimbursement level by 50%, then apply multiple procedure reduction rules.

This A/B MAC recognizes that Vertebroplasty and Vertebral Augmentation are procedures with expanding indications and will accept recommendations to reconsider the list of covered diagnoses. However, these requests for reconsideration must be submitted as a formal reconsideration and must be accompanied by complete copies of relevant peer-reviewed literature that support the recommendation.

Compliance with the provisions in this policy is subject to monitoring by post payment data analysis and subsequent medical review.

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Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

999x Not Applicable

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

99999 Not Applicable

CPT/HCPCS Codes
Group 1 Paragraph: N/A

Group 1 Codes:
22520 Percut vertebroplasty thor
22521 Percut vertebroplasty lumb
22522 Percut vertebroplasty addl

22523 Percut kyphoplasty thor
22524 Percut kyphoplasty lumbar
22525 Percut kyphoplasty add-on
22899 Spine surgery procedure
72291 Perq verte/sacroplsty fluor
72292 Perq verte/sacroplsty ct

ICD-9 Codes that Support Medical Necessity
Group 1 Paragraph: It is the responsibility of the provider to code to the highest level specified in the ICD-9-CM (e.g., to the fourth or fifth digit). The correct use of an ICD-9-CM code listed below does not assure coverage of a service. The service must be reasonable and necessary in the specific case and must meet the criteria specified in this determination.

Group 1 Codes:

170.2	MALIGNANT NEOPLASM OF VERTEBRAL COLUMN EXCLUDING SACRUM AND COCCYX
198.5	SECONDARY MALIGNANT NEOPLASM OF BONE AND BONE MARROW
200.00 - 200.08 opens in new window	RETICULOSARCOMA UNSPECIFIED SITE - RETICULOSARCOMA INVOLVING LYMPH NODES OF MULTIPLE SITES
200.10 - 200.18 opens in new window	LYMPHOSARCOMA UNSPECIFIED SITE - LYMPHOSARCOMA INVOLVING LYMPH NODES OF MULTIPLE SITES
200.20 - 200.28 opens in new window	BURKITT'S TUMOR OR LYMPHOMA UNSPECIFIED SITE - BURKITT'S TUMOR OR LYMPHOMA INVOLVING LYMPH NODES OF MULTIPLE SITES
200.30 - 200.38 opens in new window	MARGINAL ZONE LYMPHOMA, UNSPECIFIED SITE, EXTRANODAL AND SOLID ORGAN SITES - MARGINAL ZONE LYMPHOMA, LYMPH NODES OF MULTIPLE SITES
200.40 - 200.48 opens in new window	MANTLE CELL LYMPHOMA, UNSPECIFIED SITE, EXTRANODAL AND SOLID ORGAN SITES - MANTLE CELL LYMPHOMA, LYMPH NODES OF MULTIPLE SITES
200.50 - 200.58 opens in new window	PRIMARY CENTRAL NERVOUS SYSTEM LYMPHOMA, UNSPECIFIED SITE, EXTRANODAL AND SOLID ORGAN SITES - PRIMARY CENTRAL NERVOUS SYSTEM LYMPHOMA, LYMPH NODES OF MULTIPLE SITES
200.60 - 200.68 opens in new window	ANAPLASTIC LARGE CELL LYMPHOMA, UNSPECIFIED SITE, EXTRANODAL AND SOLID ORGAN SITES - ANAPLASTIC LARGE CELL LYMPHOMA, LYMPH NODES OF MULTIPLE SITES
200.70 - 200.78 opens in new window	LARGE CELL LYMPHOMA, UNSPECIFIED SITE, EXTRANODAL AND SOLID ORGAN SITES - LARGE CELL LYMPHOMA, LYMPH NODES OF MULTIPLE SITES
200.80 - 200.88 opens in new window	OTHER NAMED VARIANTS OF LYMPHOSARCOMA AND RETICULOSARCOMA UNSPECIFIED SITE - OTHER NAMED VARIANTS OF LYMPHOSARCOMA AND RETICULOSARCOMA INVOLVING LYMPH NODES OF MULTIPLE SITES
201.00 - 201.08 opens in new window	HODGKIN'S PARAGRANULOMA UNSPECIFIED SITE - HODGKIN'S PARAGRANULOMA INVOLVING LYMPH NODES OF MULTIPLE SITES
201.10 - 201.18 opens in new window	HODGKIN'S GRANULOMA UNSPECIFIED SITE - HODGKIN'S GRANULOMA INVOLVING LYMPH NODES OF MULTIPLE SITES
201.20 - 201.28 opens in new window	HODGKIN'S SARCOMA UNSPECIFIED SITE - HODGKIN'S SARCOMA INVOLVING LYMPH NODES OF MULTIPLE SITES
201.40 - 201.48 opens in new window	HODGKIN'S DISEASE LYMPHOCYTIC-HISTIOCYTIC PREDOMINANCE UNSPECIFIED SITE - HODGKIN'S DISEASE LYMPHOCYTIC-HISTIOCYTIC PREDOMINANCE INVOLVING LYMPH NODES OF MULTIPLE SITES
201.50 - 201.58 opens in new window	HODGKIN'S DISEASE NODULAR SCLEROSIS UNSPECIFIED SITE - HODGKIN'S DISEASE NODULAR SCLEROSIS INVOLVING LYMPH NODES OF MULTIPLE SITES
201.60 - 201.68 opens in new window	HODGKIN'S DISEASE MIXED CELLULARITY UNSPECIFIED SITE - HODGKIN'S DISEASE MIXED CELLULARITY INVOLVING LYMPH NODES OF MULTIPLE SITES

201.70 - 201.78 opens in new window	HODGKIN'S DISEASE LYMPHOCYTIC DEPLETION UNSPECIFIED SITE - HODGKIN'S DISEASE LYMPHOCYTIC DEPLETION INVOLVING LYMPH NODES OF MULTIPLE SITES
201.90 - 201.98 opens in new window	HODGKIN'S DISEASE UNSPECIFIED TYPE UNSPECIFIED SITE - HODGKIN'S DISEASE UNSPECIFIED TYPE INVOLVING LYMPH NODES OF MULTIPLE SITES
202.00 - 202.08 opens in new window	NODULAR LYMPHOMA UNSPECIFIED SITE - NODULAR LYMPHOMA INVOLVING LYMPH NODES OF MULTIPLE SITES
202.10 - 202.18 opens in new window	MYCOSIS FUNGOIDES UNSPECIFIED SITE - MYCOSIS FUNGOIDES INVOLVING LYMPH NODES OF MULTIPLE SITES
202.20 - 202.28 opens in new window	SEZARY'S DISEASE UNSPECIFIED SITE - SEZARY'S DISEASE INVOLVING LYMPH NODES OF MULTIPLE SITES
202.30 - 202.38 opens in new window	MALIGNANT HISTIOCYTOSIS UNSPECIFIED SITE - MALIGNANT HISTIOCYTOSIS INVOLVING LYMPH NODES OF MULTIPLE SITES
202.40 - 202.48 opens in new window	LEUKEMIC RETICULOENDOTHELIOSIS UNSPECIFIED SITE - LEUKEMIC RETICULOENDOTHELIOSIS INVOLVING LYMPH NODES OF MULTIPLE SITES
202.50 - 202.58 opens in new window	LETTERER-SIWE DISEASE UNSPECIFIED SITE - LETTERER-SIWE DISEASE INVOLVING LYMPH NODES OF MULTIPLE SITES
202.60 - 202.68 opens in new window	MALIGNANT MAST CELL TUMORS UNSPECIFIED SITE - MALIGNANT MAST CELL TUMORS INVOLVING LYMPH NODES OF MULTIPLE SITES
202.70 - 202.78 opens in new window	PERIPHERAL T CELL LYMPHOMA, UNSPECIFIED SITE, EXTRANODAL AND SOLID ORGAN SITES - PERIPHERAL T CELL LYMPHOMA, LYMPH NODES OF MULTIPLE SITES
202.80 - 202.88 opens in new window	OTHER MALIGNANT LYMPHOMAS UNSPECIFIED SITE - OTHER MALIGNANT LYMPHOMAS INVOLVING LYMPH NODES OF MULTIPLE SITES
202.90 - 202.98 opens in new window	OTHER AND UNSPECIFIED MALIGNANT NEOPLASMS OF LYMPHOID AND HISTIOCYTIC TISSUE UNSPECIFIED SITE - OTHER AND UNSPECIFIED MALIGNANT NEOPLASMS OF LYMPHOID AND HISTIOCYTIC TISSUE INVOLVING LYMPH NODES OF MULTIPLE SITES
203.00	MULTIPLE MYELOMA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION
203.01	MULTIPLE MYELOMA IN REMISSION
203.02	MULTIPLE MYELOMA, IN RELAPSE
203.10 - 203.12 opens in new window	PLASMA CELL LEUKEMIA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION - PLASMA CELL LEUKEMIA, IN RELAPSE
203.80 - 203.82 opens in new window	OTHER IMMUNOPROLIFERATIVE NEOPLASMS, WITHOUT MENTION OF HAVING ACHIEVED REMISSION - OTHER IMMUNOPROLIFERATIVE NEOPLASMS, IN RELAPSE
204.00 - 204.02 opens in new window	ACUTE LYMPHOID LEUKEMIA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION - ACUTE LYMPHOID LEUKEMIA, IN RELAPSE
204.10 - 204.12 opens in new window	CHRONIC LYMPHOID LEUKEMIA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION - CHRONIC LYMPHOID LEUKEMIA, IN RELAPSE
204.20 - 204.22 opens in new window	SUBACUTE LYMPHOID LEUKEMIA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION - SUBACUTE LYMPHOID LEUKEMIA, IN RELAPSE
204.80 - 204.82 opens in new window	OTHER LYMPHOID LEUKEMIA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION - OTHER LYMPHOID LEUKEMIA, IN RELAPSE
204.90 - 204.92 opens in new window	UNSPECIFIED LYMPHOID LEUKEMIA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION - UNSPECIFIED LYMPHOID LEUKEMIA, IN RELAPSE
205.00 - 205.02 opens in new window	ACUTE MYELOID LEUKEMIA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION - ACUTE MYELOID LEUKEMIA, IN RELAPSE

205.10 - 205.12 opens in new window	CHRONIC MYELOID LEUKEMIA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION - CHRONIC MYELOID LEUKEMIA, IN RELAPSE
205.20 - 205.22 opens in new window	SUBACUTE MYELOID LEUKEMIA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION - SUBACUTE MYELOID LEUKEMIA, IN RELAPSE
205.30 - 205.32 opens in new window	MYELOID SARCOMA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION - MYELOID SARCOMA, IN RELAPSE
205.80 - 205.82 opens in new window	OTHER MYELOID LEUKEMIA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION - OTHER MYELOID LEUKEMIA, IN RELAPSE
205.90 - 205.92 opens in new window	UNSPECIFIED MYELOID LEUKEMIA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION - UNSPECIFIED MYELOID LEUKEMIA, IN RELAPSE
213.2	BENIGN NEOPLASM OF VERTEBRAL COLUMN EXCLUDING SACRUM AND COCCYX
228.09*	HEMANGIOMA OF OTHER SITES
238.0	NEOPLASM OF UNCERTAIN BEHAVIOR OF BONE AND ARTICULAR CARTILAGE
238.5	NEOPLASM OF UNCERTAIN BEHAVIOR OF HISTIOCYTIC AND MAST CELLS
238.6	NEOPLASM OF UNCERTAIN BEHAVIOR OF PLASMA CELLS
238.79	OTHER LYMPHATIC AND HEMATOPOIETIC TISSUES
239.2	NEOPLASM OF UNSPECIFIED NATURE OF BONE SOFT TISSUE AND SKIN
255.0	CUSHING'S SYNDROME
268.2	OSTEOMALACIA UNSPECIFIED
268.9	UNSPECIFIED VITAMIN D DEFICIENCY
277.89*	OTHER SPECIFIED DISORDERS OF METABOLISM
721.7	TRAUMATIC SPONDYLOPATHY
733.00	OSTEOPOROSIS UNSPECIFIED
733.01	SENILE OSTEOPOROSIS
733.02	IDIOPATHIC OSTEOPOROSIS
733.03	DISUSE OSTEOPOROSIS
733.09*	OTHER OSTEOPOROSIS
733.13	PATHOLOGICAL FRACTURE OF VERTEBRAE
733.82	NONUNION OF FRACTURE
805.00 - 805.08 opens in new window	CLOSED FRACTURE OF CERVICAL VERTEBRA UNSPECIFIED LEVEL - CLOSED FRACTURE OF MULTIPLE CERVICAL VERTEBRAE
805.10 - 805.18 opens in new window	OPEN FRACTURE OF CERVICAL VERTEBRA UNSPECIFIED LEVEL - OPEN FRACTURE OF MULTIPLE CERVICAL VERTEBRAE
805.2	CLOSED FRACTURE OF DORSAL (THORACIC) VERTEBRA WITHOUT SPINAL CORD INJURY
805.3	OPEN FRACTURE OF DORSAL (THORACIC) VERTEBRA WITHOUT SPINAL CORD INJURY
805.4	CLOSED FRACTURE OF LUMBAR VERTEBRA WITHOUT SPINAL CORD INJURY
805.5	OPEN FRACTURE OF LUMBAR VERTEBRA WITHOUT SPINAL CORD INJURY
805.6	CLOSED FRACTURE OF SACRUM AND COCCYX WITHOUT SPINAL CORD INJURY
805.7	OPEN FRACTURE OF SACRUM AND COCCYX WITHOUT SPINAL CORD INJURY
805.8	CLOSED FRACTURE OF UNSPECIFIED PART OF VERTEBRAL COLUMN WITHOUT SPINAL CORD INJURY
805.9	OPEN FRACTURE OF UNSPECIFIED PART OF VERTEBRAL COLUMN WITHOUT SPINAL CORD INJURY
995.20	UNSPECIFIED ADVERSE EFFECT OF UNSPECIFIED DRUG, MEDICINAL AND BIOLOGICAL SUBSTANCE

Group 1 Medical Necessity ICD-9 Codes Asterisk Explanation: ** Code 228.09 may be used only for hemangiomas of the vertebral body
* Code 277.89 may be used only for eosinophilic granuloma/Histiocytosis X
* Code 733.09 is to be used only for drug-induced osteoporosis

ICD-9 Codes that DO NOT Support Medical Necessity
Paragraph: All ICD-9-CM codes **not** listed in this policy under ICD-9-CM Codes That Support Medical Necessity

above.

N/A
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General Information

Associated Information

N/A

Sources of Information and Basis for Decision
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Hardouin P, Fayada P, Leclet H, Chopin D. Kyphoplasty. *Joint Bone Spine.* May 2002;69(3):256-61.

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Collaborative Panel of the American College of Radiology, the American Society of Neuroradiology, the American Society of Interventional and Therapeutic Neuroradiology, and the American Society of Spine Radiology. Practice guideline for the performance of percutaneous vertebroplasty. Reston, VA: American College of Radiology (ACR); 2000. Effective 2001 Revised 2009

Updated Sources
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Revision History Information

Please note: The Revision History information included in this LCD prior to 1/24/2013 will now display with a Revision History Number of "R1" at the bottom of this table. All new Revision History information entries completed on or after 1/24/2013 will display as a row in the Revision History section of the LCD and numbering will begin with "R2".

Revision History Date	Revision History Number	Revision History Explanation	Reason(s) for Change
11/01/2013	R2	This LCD was revised to reflect the corporate name change from Noridian Administrative Services, LLC to Noridian Healthcare Solutions, LLC that was effective on 05/01/2013. No other changes were made in this revision.	• Other (Corporate name change)
09/16/2013	R1	Removed J1 from the following sentence under the Coverage Indications, Limitations and/or Medical Necessity section, "Preoperative diagnostic imaging studies are not the subject of this policy, but are the subjects of other J1 A/B MAC policies."	• Other

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Associated Documents

Attachments N/A

Related Local Coverage Documents N/A

Related National Coverage Documents N/A

Public Version(s) Updated on 10/28/2013 with effective dates 11/01/2013 - N/A Updated on 06/17/2013 with effective dates 09/16/2013 - 10/31/2013 Updated on 06/07/2013 with effective dates 09/16/2013 - N/A Back to Top

Keywords

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