Geisinger

Geisinger Health Plan Policies and Procedure Manual

Policy: MP114

Section: Medical Benefit Policy

Subject: Vertebroplasty and Percutaneous Kyphoplasty

Applicable Lines of Business

Commercial	**X**	**CHIP**	**X**
Medicare	**X**	**ACA**	**X**
Medicaid	**X**		

I. Policy: Vertebroplasty and Percutaneous Kyphoplasty

II. Purpose/Objective:

To provide a policy of coverage regarding Vertebroplasty and Percutaneous Kyphoplasty

III. Responsibility:

A. Medical Directors
B. Medical Management

IV. Required Definitions

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards of good medical treatment practiced by the general medical community.
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment

Medically Necessary — A service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- Will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking

into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age

DESCRIPTION:
Vertebroplasty is an interventional radiology technique that has been investigated as a therapy for pain relief and bone strengthening in vertebral collapse secondary to osteoporosis, painful vertebral hemangioma, osteolytic metastases and multiple myeloma. Polymethylmethacrylate is inserted through a fluoroscopically guided needle into the weakened vertebral body. Percutaneous sacroplasty, a variation of vertebroplasty, is an evolving technique that has been proposed for the treatment of sacral insufficiency fractures.
Kyphoplasty (also known as Percutaneous Vertebral Augmentation) is a minimally invasive procedure used in the treatment of vertebral fractures. This technique involves the use of an inflatable bone tamp (i.e. KyphX™) inserted into a weakened or collapsed vertebral body. This procedure, used in conjunction with vertebroplasty, is used to restore vertebral body height after vertebral collapse related to osteoporosis, reduce pain, and restore mobility in affected persons.

Geisinger Health Plan requires prior authorization through Cohere for Cardiology services for members enrolled in its Commercial HMO and PPO, Medicare Advantage. GHP Family Medicaid and CHIP products. To direct the application of these services for Geisinger Health Plan members, Cohere utilizes its proprietary clinical criteria, Utilization Management decision-support tools, and evidence-based medical treatment guidelines. For more information about the services that require prior authorization, refer to https://payerinfo.zendesk.com/hc/en-us

Medicaid Business Segment:
Any requests for services that do not meet criteria set in the PARP may be evaluated on a case by case basis

CODING ASSOCIATED WITH: Vertebroplasty
The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services.

22510
22511
22512
22513
22514
22515

Medicaid Business Segment:
Any requests for services, that do not meet criteria set in the PARP, may be evaluated on a case by case basis.

LINE OF BUSINESS:

Eligibility and contract specific benefit limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD's and NCD's will supercede this policy. For PA Medicaid Business segment, this policy applies as written.

This policy will be revised as necessary and reviewed no less than annually.

Devised: 8/03

Revised: 5/04; 5/05 (grammatical); 7/10 (exclusions and coding); 2/11(removal of PA); 7/15 (added indication), 7/16, 6/20 (Medicare coverage citation); 12/20 (Transition to Health Help); 10/23 (transition to Cohere)

Reviewed: 5/06; 5/07; 5/08; 5/09; 6/11, 7/12, 7/13, 7/14, 6/17, 6/18, 6/19, 6/21, 6/22