Priority Health	BILLING POLICY No. 095
PERCUTANEOUS VERTEBRAL AUGMENTATION (PVA) FOR VERTEBRAL COMPRESSION FRACTURE (VCF)	
Date of origin: June 19, 2025	**Review dates: None yet recorded**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise specified
- Medicaid follows MDHHS unless otherwise specified

DEFINITION

Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF)

Percutaneous vertebroplasty is an interventional technique involving the fluoroscopically guided injection of polymethylmethacrylate into a weakened vertebral body. The technique has been investigated to provide mechanical support and symptomatic relief in those with osteoporotic vertebral compression fractures or those with osteolytic lesions of the spine (e.g., multiple myeloma, metastatic malignancies); as a treatment for sacral insufficiency fractures; and as a technique to limit blood loss related to surgery.

Percutaneous balloon kyphoplasty, radiofrequency kyphoplasty (RFK) and mechanical vertebral augmentation are interventional techniques involving the fluoroscopically guided injection of polymethylmethacrylate into a cavity created in the vertebra l body with a balloon or mechanical device.

Sacroplasty evolved from the treatment of insufficiency fractures in the thoracic and lumbar vertebrae with vertebroplasty. The procedure, essentially identical, entails guided injection of PMMA through a needle inserted into the fracture zone. It's most often described as a minimally invasive procedure employed as an alternative to conservative management for sacral insufficiency fractures (SIFs).

- **Vertebroplasty (CPT codes 22510, 22511, 22512)**: Involves injecting cement into the vertebral body using image guidance to reinforce its structure
- **Vertebral Augmentation (CPT codes 22513, 22514, 22515)**: Involves creating a mechanical cavity within the vertebral body followed by cement injection under image guidance. The key difference is the creation of a cavity.
- **Sacral Augmentation (Category III codes 0200T, 0201T)**: Refers to the injection of material into the sacral vertebral body, with or without cavity creation

Vertebral Augmentation: A minimally invasive procedure for stabilization and restoration of a vertebra to treat painful, pathologic fractures. The more common techniques in current use are vertebroplasty or kyphoplasty. Sacroplasty or coccygeoplasty are the terms used when vertebroplasty or kyphoplasty is used to treat insufficiency fractures of the sacrum or coccyx, respectively.

- **Vertebroplasty**: A percutaneous augmentation procedure that involves image guided injection of polymethylmethacrylate [PMMA] cement
- **Kyphoplasty**: A percutaneous augmentation procedure that is a variant of vertebroplasty. This procedure uses instrumentation or a device to re-establish vertebral height. Kyphoplasty techniques include balloon kyphoplasty and mechanical kyphoplasty.

Balloon Kyphoplasty: A percutaneous augmentation technique that involves the use of a specialized balloon to expand collapsed vertebrae, which then allows injection of PMMA

- **Mechanical Kyphoplasty**: A percutaneous augmentation technique using a device other than a balloon to expand collapsed vertebrae. Types of mechanical kyphoplasty techniques include, but aren't limited to, the following:
    - **Roadiofrequency Kyphoplasty**: A percutaneous kyphoplasty technique utilizing the StabiliT® Vertebral Augmentation System (StabiliT®). This technique uses radiofrequency energy to modify ultra-high viscosity cement to a desired consistency. This ultra-high viscosity cement is introduced into the vertebral body to expand the collapsed vertebrae.
    - **Kiva® VCF System**: A percutaneous kyphoplasty technique using a cannula-deployed Kiva® coil to insert a spiral PolyEtherEtherKetone (PEEK) implant which serves as a conduit for PMMA cement placement
    - **SpineJack®**: A percutaneous kyphoplasty technique using an expandable intervertebral body implant to restore vertebral height followed by injection of PMMA cement to keep the implant in place
    - **Vertebral Body Stenting**: A percutaneous kyphoplasty technique using an expandable metal stent with PMMA cement resulting in a stent

MEDICAL POLICY

- Spine Procedures (#91581)

See a listing of Priority Health medical policies in our Provider Manual.

Priority Health has contracted with TurningPoint Healthcare Solutions LLC (TurningPoint) for management of some musculoskeletal services. Medical necessity for these procedures will be governed by the applicable TurningPoint clinical guidelines. Get information in our Provider Manual on how to access these clinical guidelines.

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Coding specifics

- **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, (e.g., 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, (e.g., 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, (e.g., 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)
- **0200T**: Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used, one or more needles, includes imaging guidance and bone biopsy, when performed

- **0201T**: Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, two or more needles, includes imaging guidance and bone biopsy, when performed.

One primary procedure code is reported with an add-on code for each additional level to which the procedure is performed.

The sacrum and sacral procedures are reported only once per encounter.

If the procedure involves multiple levels across different regions (e.g., both thoracic and lumbar), use the appropriate initial code (22513 or 22514) and then report code 22515 for each additional level.

Example:

- If a PVA is performed on T10, L1 and L4, you would report:
    - 22513 (for T10, initial thoracic level)
    - 22515 (for L1, additional lumbar level)
    - 22515 (for L4, additional lumbar level)

Medicare Medically Unlikely Edit (MUE) rules may apply. Review CPT lay description and consult MUE information prior to billing. Get specific rules on MUE from CMS.

Percutaneous vertebral augmentation procedures (22513-22515) are for the thoracic and lumbar areas only. If cervical vertebral augmentation is performed, the unlisted CPT code (22899) should be reported.

Bone biopsy (CPT codes 20225, 20250 or 20251) is integral to both percutaneous vertebroplasty and vertebral augmentation procedures (CPT codes 22510, 22511, 22512, 22513, 22514, 22515) and shouldn't be billed separately unless performed at a different site or during a different session. When performed at a separate site, modifier 59 or XS must be used, and documentation must clearly support the distinct procedure.

Payment for vertebroplasty and vertebral augmentation is all-inclusive, covering the entire procedure, including injection and intraosseous venography. Separate payment for venography performed during the operative session isn't allowed and shouldn't be billed separately.

Vertebroplasty and vertebral augmentation procedures also includes moderate sedation and fracture reduction when performed.

Reimbursement rates

Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. See our fee schedules (login required).

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the provider. In addition, the provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

Documentation is crucial for supporting the medical necessity of services. Ensure your documentation supports the medical necessity of the procedure, including relevant medical history, physical examination findings, diagnostic test results and other non-invasive treatment attempts.

Anatomical site identification / details

Always specify the anatomical site of each procedure and provide detailed descriptions and precise terms.

Specify the type of imaging guidance used (e.g., fluoroscopy, CT, ultrasound) and detail how it was utilized for needle or device placement.

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list below may not be an all-inclusive list. Learn more about modifier use in our Provider Manual.

- Modifiers 50, LT/RT are not required for CPT codes 22510, 225511, 22512, 22513, 22514 and 22515. The CPT descriptor is per vertebral body, unilateral or bilateral.

- Modifier 59 or XS may be appropriate. Apply these modifiers correctly to indicate separate and distinct procedures when appropriate. Ensure documentation supports their use by clearly describing the separate nature each of procedure performed.

Place of service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition.

REFERENCES

- Article - Billing and Coding: Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF) (A57630) (CMS)
- LCD - Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF) (L38213) (CMS)
- Cigna Medical Coverage Policies – Musculoskeletal Primal Vertebral Augmentation (Percutaneous Vertebroplasty-Kyphoplasty) and Sacroplasty Guidelines (Cigna)
- Vertebral Fractures – Proper Documentation & Coding (StreamlineMD)
- Medical policy – Percutaneous Vertebroplasty/Mechanical Vertebral Augmentation (Excellus)
- Medical policy – Percutaneous Vertebroplasty and Percutaneous Vertebral Augmentation or Vertebral Augmentation (Formerly Kyphoplasty) (MCS)

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made