Vertebroplasty/Kyphoplasty Coverage Tool for Medicare Patient

**Patient Criteria**

□ Vertebral compression fracture (VCF) **≤4 months old;** T5-L5 levels only; 3 or fewer levels per procedure

□ Pain level is: □ \_\_\_\_ on VAS 1-10 pain scale (≤7)

□ and/or pain interferes with independent ADLs when ADLs were previously independent

□ Pain refractory to non-invasive pain intervention(s)

Interventions attempted:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Fracture confirmed by

□ plain x-ray date \_\_\_\_\_\_\_\_\_\_ OR □ MRI date \_\_\_\_\_\_\_\_\_\_\_\_

□ Patient does NOT have unstable fracture or require stabilization procedure

□ Patient does NOT have Osteomyelitis or any other active infection including UTI

□ Patient does NOT have uncorrected coagulation disorders.

□ Patient does NOT have bone fragment retropulsion or radicular symptoms related to the VCF level

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□ Patient does NOT have painful metastases to other areas of the spine; spinal cord compression; Primary bone tumor or a solitary plasmacytoma

□ Patient does NOT have a known allergy to any of the materials; or any condition that is a contraindication in the FDA labeling

□ Patient does NOT have foraminal stenosis or other spinal degenerative disease, facet arthropathy or other significant coexisting spinal or bony pain generators

**Documentation Requirements Prior to Procedure**

□ Comprehensive pain evaluation and examination.

□ Pain management treatment plan addressing all pain generators, and beginning with the least invasive approach.

□ Complete history and physical examination by operating provider.

□ Appropriate imaging has been performed pre-operatively and the findings correlate unequivocally with the patient’s pain.

□ Patient’s pain is predominantly, if not solely, related to the demonstrated fracture.

**Documentation Requirements for Procedure and post-procedure**

□ Procedure must be performed with CT or fluoroscopic, real-time imaging guidance, with retained images of final trocar placement and retained images of the vertebral body at the end of the procedure.

□ Detailed operative procedure narrative report.

□ Plan for F/U patient assessment at 1 week, 1 month, 3 months and 1 year post-operatively with outcomes. Telephone F/U is acceptable. (3 month and 1 year F/U may be deferred to PCP with appropriate communication and documentation.) Documentation will include patient’s comfort/activity/pain scores.

**Contraindications/Limitations**

1. Not payable when performed immediately following acute compression fractures or diagnosis of them.
   1. Delay may not always be in patient’s best interest. If so; provider must clearly and legibly document the rational for this decision in the medical record.
2. Will not be paid in combination with any open spine procedure
3. Bone biopsy done at the same level as part of same procedure will not be payable

REMINDER: ***Absent clear medical record documentation to the contrary, these procedures are not performed on an inpatient basis and do not, in and of themselves, ever require inpatient admission.***