MEDICAL POLICY – 6.01.25
Percutaneous Vertebroplasty and Sacroplasty

BCBSA Ref. Policy: 6.01.25
Effective Date: July 1, 2023
Last Revised: June 12, 2023
Replaces: 6.01.520

RELATED MEDICAL POLICIES:
6.01.38 Percutaneous Balloon Kyphoplasty, Radiofrequency Kyphoplasty, and Mechanical Vertebral Augmentation
6.01.527 Diagnosis and Treatment of Sacroiliac Joint Pain

Select a hyperlink below to be directed to that section.

POLICY CRITERIA | DOCUMENTATION REQUIREMENTS | CODING
RELATED INFORMATION | EVIDENCE REVIEW | REFERENCES | HISTORY

∞ Clicking this icon returns you to the hyperlinks menu above.

Introduction

Osteoporosis or cancer in the bones can cause the vertebrae (the bone in the spine) to weaken. They may become so weak that they collapse. This is known as a compression fracture. The collapse usually happens at the front side of the vertebra, creating a vertebra that looks a bit like a wedge. Percutaneous vertebroplasty is a non-surgical procedure to stabilize a spinal compression fracture. A hollow needle is inserted through the skin and into the damaged bone. Bone cement is then injected into the bone. This policy describes when this procedure may be considered medically necessary. Percutaneous sacroplasty is a similar procedure, but the bone cement is placed in the sacrum. The sacrum is the bone at the bottom of the spine and forms the back of the pelvis. Using this technique for the sacrum is investigational. There are not yet enough medical studies to show whether percutaneous sacroplasty is effective.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.
## Policy Coverage Criteria

<table>
<thead>
<tr>
<th>Service</th>
<th>Medical Necessity</th>
</tr>
</thead>
</table>
| Percutaneous vertebroplasty | **Percutaneous vertebroplasty may be considered medically necessary for the treatment of:**  
  • Symptomatic osteoporotic vertebral fractures that have failed to respond to conservative treatment (e.g., analgesics, physical therapy, and rest) for at least 6 weeks  
  OR  
  • Symptomatic osteoporotic vertebral fractures that happened less than 6 weeks ago and have led to hospitalization or persist at a level that prevents ambulation  
  OR  
  • Severe pain due to osteolytic lesions of the spine related to multiple myeloma or metastatic malignancies  
  
  **Note:** There is considerable variability in pain scores based on the literature review. If the individual is in intractable pain that cannot be managed safely with conservative treatment for at least 1 week, then percutaneous vertebroplasty surgery may be considered sooner than 6 weeks.  

  **Percutaneous vertebroplasty is considered investigational for all other indications, including use in acute vertebral fractures due to osteoporosis or trauma that have not led to hospitalization or prevent ambulation.**                                                                                                                                                                                                                                                                                                                                                                                                 |
|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| Percutaneous sacroplasty  | **Percutaneous sacroplasty is considered investigational for all indications, including use in sacral insufficiency fractures due to osteoporosis and sacral lesions due to multiple myeloma or metastatic malignancies.**                                                                                                                                                                                                                                                                                                                                                                                                              |

## Documentation Requirements

**Clinical documentation of one of the following conditions:**
Documentation Requirements

- Symptomatic osteoporotic vertebral fractures that have failed to respond to conservative treatment (e.g., analgesics, physical therapy, and rest) for at least 6 weeks
  OR
- Symptomatic osteoporotic vertebral fractures that happened less than 6 weeks ago and have led to hospitalization or persist at a level that prevents walking
  OR
- Severe pain due to osteolytic lesions of the spine related to multiple myeloma or metastatic malignancies

Coding

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>CPT</td>
<td></td>
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<tr>
<td>0200T</td>
<td>Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used, 1 or more needles, includes imaging guidance and bone biopsy, when performed</td>
</tr>
<tr>
<td>0201T</td>
<td>Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, 2 or more needles, includes imaging guidance and bone biopsy, when performed</td>
</tr>
<tr>
<td>22510</td>
<td>Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic</td>
</tr>
<tr>
<td>22511</td>
<td>Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral</td>
</tr>
<tr>
<td>22512</td>
<td>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)</td>
</tr>
<tr>
<td>HCPC</td>
<td></td>
</tr>
<tr>
<td>C7504</td>
<td>Percutaneous vertebroplasties (bone biopsies included when performed), first cervicothoracic and any additional cervicothoracic or lumbosacral vertebral bodies, unilateral or bilateral injection, inclusive of all imaging guidance (new code effective 1/1/2023)</td>
</tr>
<tr>
<td>C7505</td>
<td>Percutaneous vertebroplasties (bone biopsies included when performed), first lumbosacral and any additional cervicothoracic or lumbosacral vertebral bodies,</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
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<td>-------------</td>
</tr>
<tr>
<td></td>
<td>unilateral or bilateral injection, inclusive of all imaging guidance (new code effective 1/1/2023)</td>
</tr>
</tbody>
</table>

**Note:** CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). HCPCS codes, descriptions and materials are copyrighted by Centers for Medicare Services (CMS).

**Related Information**

**Benefit Application**

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

**Evidence Review**

**Description**

Percutaneous vertebroplasty is an interventional technique involving the fluoroscopically guided injection of polymethyl methacrylate (PMMA) into a weakened vertebral body. The technique has been investigated to provide mechanical support and symptomatic relief in individuals 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.

**Background**

**Treatment of Vertebral Compression Fracture**

Chronic symptoms do not tend to respond to the management strategies for acute pain, such as bed rest, immobilization or bracing device, and analgesic medication, sometimes including narcotic analgesics. The source of chronic pain after a vertebral compression fracture may not be from the vertebra itself but may be predominantly related to strain on muscles and ligaments.
secondary to kyphosis. This type of pain frequently does not improve with analgesics and may be better addressed through exercise or physical therapy. Improvements in pain and ability to function are the principal outcomes of interest for treatment of osteoporotic fractures.

**Treatment of Sacral Insufficiency Fractures**

Similar interventions are used for sacral and vertebral fractures and include bed rest, bracing, and analgesics. Initial clinical improvements may occur quickly; however, resolution of all symptoms may not occur for 9 to 12 months.¹²

**Vertebral and Sacral Body Metastasis**

Metastatic malignant disease of the spine generally involves the vertebrae/sacrum, with pain being the most frequent complaint.

**Treatment Vertebral and Sacral Body Metastasis**

While radiotherapy and chemotherapy are frequently effective in reducing tumor burden and associated symptoms, pain relief may be delayed days to weeks, depending on tumor response. Further, these approaches rely on bone remodeling to regain strength in the vertebrae/sacrum, which may necessitate supportive bracing to minimize the risk of vertebral/sacral collapse during healing. Improvements in pain and function are the primary outcomes of interest for treatment of bone malignancy with percutaneous vertebroplasty or sacroplasty.

**Surgical Treatment Options**

**Percutaneous Vertebroplasty**

Vertebroplasty is a surgical procedure that involves the injection of synthetic cement (e.g., PMMA, bis-glycidal dimethacrylate [Cortoss]³) into a fractured vertebra. It has been suggested that vertebroplasty may provide an analgesic effect through mechanical stabilization of a fractured or otherwise weakened vertebral body. However, other mechanisms of effect have been postulated, including thermal damage to intraosseous nerve fibers.
**Percutaneous Sacroplasty**

Sacroplasty evolved from the treatment of insufficiency fractures in the thoracic and lumbar vertebrae with vertebroplasty. The procedure, essentially identical to vertebroplasty, entails guided injection of PMMA through a needle inserted into the fracture zone. Although first described in 2000 as a treatment for symptomatic sacral metastatic lesions,4,5 it is most often described as a minimally invasive alternative to conservative management6,7,8 for sacral insufficiency fractures.

Pain and function are subjective outcomes and, thus, may be susceptible to placebo effects. Furthermore, the natural history of pain and disability associated with these conditions may vary. Therefore, controlled comparison studies would be valuable to demonstrate the clinical effectiveness of vertebroplasty and sacroplasty over any associated nonspecific or placebo effects and to demonstrate the effect of treatment compared with alternatives such as continued medical management.

In all clinical situations, adverse events related to complications from vertebroplasty and sacroplasty are the primary harms to be considered. Principal safety concerns relate to the incidence and consequences of leakage of the injected PMMA or another injectate.

**Summary of Evidence**

For individuals who have symptomatic osteoporotic vertebral fractures that are between six weeks and one year old who receive vertebroplasty, the evidence includes two randomized sham-controlled trials, nonblinded randomized controlled trials (RCTs) comparing vertebroplasty with conservative management, and several meta-analyses. The relevant outcomes are symptoms, functional outcomes, quality of life, hospitalizations, medication use, and treatment-related morbidity. Despite the completion of multiple RCTs, including two with sham controls, the efficacy of vertebroplasty for painful osteoporotic compression fractures remains uncertain. Two meta-analysis studies, which included the 2 sham-controlled trials, have demonstrated mixed results. The two studies had methodologic issues, including the choice of sham procedure and the potential effect of the sham procedure to have a therapeutic effect by reducing pain. Questions have also been raised about the low percentage of individuals screened who participated in the trial, the volume of polymethylmethacrylate injected, and the inclusion of individuals with chronic pain. Other meta-analyses had numerous limitations due to the heterogeneity of included studies or not specifying the timeframe for osteoporotic vertebral compression fractures. Overall, conclusions about the effect of vertebroplasty remain unclear.
The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with symptomatic osteoporotic vertebral fractures that are less than six weeks old who receive vertebroplasty, the evidence includes a randomized sham-controlled trial and nonblinded RCTs comparing vertebroplasty with conservative management. The relevant outcomes are symptoms, functional outcomes, quality of life, hospitalizations, medication use, and treatment-related morbidity. For acute fractures, conservative therapy consisting of rest, analgesics, and physical therapy is an option, and symptoms will resolve in a large percentage of individuals with conservative treatment only. However, a sham-controlled randomized trial in individuals who had severe pain of fewer than six weeks in duration found a significant benefit of vertebroplasty for the treatment of osteoporotic vertebral fractures at the thoracolumbar junction. Other RCTs without sham controls have reported that vertebroplasty is associated with significant improvements in pain and reductions in the duration of bed rest. Given the high morbidity associated with extended bed rest in older adults, this procedure is considered to have a significant health benefit. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with sacral insufficiency fractures who receive sacroplasty, the evidence includes two prospective cohort studies and a case series. The relevant outcomes are symptoms, functional outcomes, quality of life, hospitalizations, medication use, and treatment-related morbidity. No RCTs have been reported. The available evidence includes a prospective cohort study and a retrospective series with 243 individuals. These studies have reported rapid and sustained decreases in pain following percutaneous sacroplasty. Additional literature has mostly reported immediate improvements following the procedure. However, due to the small size of the evidence base, the harms associated with sacroplasty have not been adequately studied. The evidence is insufficient to determine that the technology results in an improvement in the net health outcomes.

**Ongoing and Unpublished Clinical Trials**

Some currently ongoing and unpublished trials that might influence this policy are listed in Table 1.
Table 1. Summary of Key Trials

<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unpublished</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCT02489825</td>
<td>Pilot Study: Does Preventive Adjacent Level Cement Augmentation Positively Affect Reoperation Rates After Osteoporotic Vertebral Compression Fractures?</td>
<td>100</td>
<td>June 2019</td>
</tr>
<tr>
<td>NCT02902250</td>
<td>The Comparative Study About the Effect of Vertebral Body Decompression Procedure and Conservative Treatment for Benign Vertebral Compression Fracture - Prospective Randomized Control Study</td>
<td>80</td>
<td>Feb 2022</td>
</tr>
<tr>
<td>NCT03617094</td>
<td>Early Percutaneous Vertebroplasty Versus Standard Conservative Treatment in Thoracolumbar Vertebral Fractures. Monocentric, Prospective, Randomised and Compared Clinical Study</td>
<td>42</td>
<td>Oct 2020</td>
</tr>
</tbody>
</table>

NCT: national clinical trial

Clinical Input from Physician Specialty Societies and Academic Medical Centers

While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

2014 Input

In response to requests, input was received from two physician specialty societies and three academic medical centers while this policy was under review in 2014. Input was sought on the treatment of acute vertebral fractures when there is severe pain that has led to hospitalization or persists at a level that prevents ambulation, and on the treatment of traumatic fractures that have remained symptomatic after six weeks of conservative treatment. Input on these issues was mixed.
2008 Input

In response to requests, input was received from five physician specialty societies and two academic medical centers while this policy was under review in 2008. Unsolicited input was received from a sixth physician specialty society. All reviewers disagreed with the proposed policy and provided references in support of the use of vertebroplasty. Vertebroplasty has been investigated as an intervention to provide mechanical support and symptomatic relief in patients with an osteoporotic vertebral compression fracture and in those with osteolytic lesions of the spine (i.e., multiple myeloma, metastatic malignancies). Clinical input obtained in 2008 provided uniform support for the use of vertebroplasty in painful osteoporotic fractures. Reconsideration of the available evidence (consistent results of numerous case series, including large prospective reports) and evaluation of the input led to a conclusion that the evidence was sufficient to determine that vertebroplasty is a reasonable treatment option in patients with vertebral fractures who have failed to respond to conservative treatment (at least six weeks with analgesics, physical therapy, and rest). It is also clinically reasonable to consider the evidence supporting the clinical benefit of vertebroplasty in the osteoporotic vertebral fracture to support its use in osteolytic lesions of the spine (e.g., multiple myeloma, metastatic malignancies).

Practice Guidelines and Position Statements

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the policy conclusions.

Guidelines or position statements will be considered for inclusion if they were issued by, or jointly by, a U.S. professional society, an international society with U.S. representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

American College of Radiology

In 2022, the American College of Radiology (ACR) revised its Appropriateness Criteria for the use of percutaneous vertebral augmentation in the management of vertebral compression fractures.\textsuperscript{46} Table 2 shows the appropriateness categories for each variant.
Table 2. ACR Appropriateness Criteria for the use of Percutaneous Vertebral Augmentation for the Management of Vertebral Compression Fractures

<table>
<thead>
<tr>
<th>Variants</th>
<th>Appropriateness Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Asymptomatic, osteoporotic VCF. Initial treatment&quot;</td>
<td>Usually Not Appropriate</td>
</tr>
<tr>
<td>&quot;Symptomatic osteoporotic VCF with bone marrow edema or intravertebral cleft. Initial treatment&quot;</td>
<td>Usually Appropriate</td>
</tr>
<tr>
<td>&quot;New symptomatic VCF. History of prior vertebroplasty or surgery. Initial treatment.&quot;</td>
<td>Usually Appropriate</td>
</tr>
<tr>
<td>&quot;Benign VCF with worsening pain, deformity, or pulmonary dysfunction. Initial treatment&quot;</td>
<td>Usually Appropriate</td>
</tr>
<tr>
<td>&quot;Pathological VCF with ongoing or increasing mechanical pain. Initial treatment&quot;</td>
<td>Usually Appropriate</td>
</tr>
</tbody>
</table>

ACR: American College of Radiology; CT: computed tomography; MRI: magnetic resonance imaging; VCF: vertebral compression fracture.

In 2014, the ACR and seven other medical specialty associations, including the Society for Interventional Radiology, updated a 2012 joint position statement on percutaneous vertebral augmentation.16 The statement indicated that:

"percutaneous vertebral augmentation with the use of vertebroplasty or kyphoplasty is a safe, efficacious, and durable procedure in appropriate patients with symptomatic osteoporotic and neoplastic fractures, when performed in accordance with public standards...only when nonoperative medical therapy has not provided adequate pain relief or pain is significantly altering patient’s quality of life.”

Society of Interventional Radiology

In a 2014 quality improvement guideline for percutaneous vertebroplasty from the Society for Interventional Radiology, failure of medical therapy was defined as follows47:

1. For a patient rendered non-ambulatory as a result of pain from a weakened or fractured vertebral body, pain persisting at a level that prevents ambulation despite 24 hours of analgesic therapy;

2. For a patient with sufficient pain from a weakened or fractured vertebral body that physical therapy is intolerable, pain persisting at that level despite 24 hours of analgesic therapy; or
3. For any patient with a weakened or fractured vertebral body, unacceptable side effects such as excessive sedation, confusion, or constipation as a result of the analgesic therapy necessary to reduce pain to a tolerable level.

American Academy of Orthopaedic Surgeons

In 2011, the American Academy of Orthopaedic Surgeons (AAOS) published practice guidelines on the treatment of osteoporotic spinal compression fractures. The AAOS approved a strong recommendation against the use of vertebroplasty for patients who “present with an acute osteoporotic spinal compression fracture and are neurologically intact.”

National Institute for Health and Care Excellence

In 2003, NICE concluded in its guidance on percutaneous vertebroplasty that the current evidence on the safety and efficacy of vertebroplasty for vertebral compression fractures appeared “adequate to support the use of this procedure” to “provide pain relief for people with severe painful osteoporosis with loss of height and/or compression fractures of the vertebral body...” The guidance also recommended that the procedure be limited to patients whose pain is refractory to more conservative treatment. A 2013 NICE guidance indicated that percutaneous vertebroplasty and percutaneous balloon kyphoplasty “are recommended as options for treating osteoporotic vertebral compression fractures” in persons having “severe, ongoing pain after a recent, unhealed vertebral fracture despite optimal pain management” and whose “pain has been confirmed to be at the level of the fracture by physical examination and imaging.”

In 2008, NICE issued guidance on the diagnosis and management of adults with metastatic spinal cord compression. This guidance indicated that vertebroplasty or kyphoplasty should be considered for “patients who have vertebral metastases and no evidence of MSCC [metastatic spinal cord compression] or spinal instability if they have: mechanical pain resistant to conventional pain management, or vertebral body collapse.”

American Society of Pain and Neuroscience

In 2021, the American Society of Pain and Neuroscience (ASPN) published practice guidelines for the interventional management of cancer-associated pain. The guideline included a best practice statement that stated, “vertebral augmentation should be strongly considered for...”
patients with symptomatic vertebral compression fractures from spinal metastases (evidence level 1-A).” However, ASPN noted that there is little data to suggest the superiority of either vertebroplasty or kyphoplasty when treating malignant vertebral compression fractures.

**Medicare National Coverage**

There is no national coverage determination.

**Regulatory Status**

Vertebroplasty is a surgical procedure and, as such, is not subject to U.S. Food and Drug Administration (FDA) approval.

PMMA bone cement was available as a drug product before enactment of FDA’s device regulation and was at first considered what FDA terms a “transitional device.” It was transitioned to a class III device requiring premarketing applications. Several orthopedic companies have received approval of their bone cement products since 1976. In 1999, PMMA was reclassified from class III to class II, which requires future 510(k) submissions to meet “special controls” instead of “general controls” to assure safety and effectiveness. Thus, use of PMMA in vertebroplasty represented an off-label use of an FDA-regulated product before 2005. In 2005, PMMA bone cements such as Spine-Fix® Biomimetic Bone Cement and Osteopal® V were cleared for marketing by FDA through the 510(k) process for the fixation of pathologic fractures of the vertebral body using vertebroplasty procedures.

The use of PMMA in sacroplasty is an off-label use of an FDA-regulated product (bone cements such as Spine-Fix® Biomimetic Bone Cement [Teknimed] and Osteopal® V [Heraeus]), because the 510(k) approval was for the fixation of pathologic fractures of the vertebral body using vertebroplasty procedures. Sacroplasty was not included. FDA product code: NDN.

In 2009, Cortoss® (Stryker) Bone Augmentation Material was cleared for marketing by FDA through the 510(k) process. Cortoss® is a nonresorbable synthetic material that is a composite resin-based, bis-glycidal dimethacrylate. FDA classifies this product as a PMMA bone cement.

In 2010, the Parallax® Contour® Vertebral Augmentation Device (ArthroCare) was cleared for marketing by FDA through the 510(k) process. There have been several other augmentation and bone expander devices (e.g., Balex® Bone Expander System, Arcadia® Balloon Catheter, Kyphon Element® Inflatable Bone Tamp) that were also cleared for marketing by FDA through the
510(k) process. These devices create a void in cancellous bone that can then be filled with bone cement. FDA product code: HXG.

References

15. Blue Cross and Blue Shield Technology Evaluation Center (TEC). Percutaneous vertebroplasty or kyphoplasty for vertebral fractures caused by osteoporosis or malignancy. TEC Assessments. 2008;Volume 23:Tab 5.
16. Barr JD, Jensen ME, Hirsch JA, et al. Position statement on percutaneous vertebral augmentation: a consensus statement developed by the Society of Interventional Radiology (SIR), American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS), American College of Radiology (ACR), American Society of Neuroradiology (ASNR),


<table>
<thead>
<tr>
<th>Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>06/12/12</td>
<td>New policy, add to Radiology section. Policy replaces 6.01.520 in conjunction with 6.01.38.</td>
</tr>
<tr>
<td>09/25/12</td>
<td>Update Coding Section – ICD-10 codes are now effective 10/01/2014.</td>
</tr>
<tr>
<td>07/24/13</td>
<td>Replace policy. Rationale updated based on a literature review through March 2013. ACR 2012 practice guideline added. References 31, 33, 34, 37 added; others renumbered or removed. Policy statements unchanged.</td>
</tr>
<tr>
<td>06/19/14</td>
<td>Annual Review. Policy updated with literature review through March 25, 2014; references 22, 31, 40-42, and 45-46 added; policy statements unchanged. ICD-9 procedure code 81.65 removed; this is performed outpatient – ICD-10 procedure codes also removed, along with both sets of diagnosis codes.</td>
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<tr>
<td>01/12/15</td>
<td>Coding update. New CPT codes 22510-22515, effective 1/1/15, added to policy; notation made regarding CPT codes 22520-22522 and 72291-72292, deleted as of 12/31/14.</td>
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<tr>
<td>08/11/15</td>
<td>Annual Review. Policy updated with literature review through March 3, 2015; references 18 and 27 added; Reworded the third policy statement for clarity: Percutaneous vertebroplasty is considered investigational for all other indications not listed above.</td>
</tr>
<tr>
<td>08/01/16</td>
<td>Annual Review, approved July 12, 2016. No change to policy statements. No new RCTs identified.</td>
</tr>
<tr>
<td>06/06/17</td>
<td>Coding update, removed HCPCS codes S2360 and S2361 as they were terminated 01/01/16.</td>
</tr>
<tr>
<td>08/01/17</td>
<td>Annual Review, approved July 18, 2017. Policy moved into the new format. Policy updated with literature review through March 23, 2017; references 9, 16, 26-27, and 30-31 added; vertebroplasty may be medically necessary in vertebral fractures of less than 6 weeks in duration that prevent ambulation.</td>
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<tr>
<td>07/01/18</td>
<td>Annual Review, approved June 22, 2018. Policy updated with literature review through February 2018; references 20, 28, and 36 added. Policy statements unchanged.</td>
</tr>
<tr>
<td>07/01/19</td>
<td>Annual Review, approved June 4, 2019. Policy updated with literature review through February 2019; references added. Policy statements unchanged.</td>
</tr>
<tr>
<td>04/01/20</td>
<td>Delete policy, approved March 10, 2020. This policy will be deleted effective July 2, 2020, and replaced with InterQual criteria for dates of service on or after July 2, 2020.</td>
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<tr>
<td>06/10/20</td>
<td>Interim Review, approved June 9, 2020, effective June 10, 2020. This policy is reinstated immediately and will no longer be deleted or replaced with InterQual criteria on July 2, 2020.</td>
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<td>06/30/2020</td>
<td>Coding update. Removed 0200T and 0201T.</td>
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<td>Comments</td>
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<tr>
<td>07/01/21</td>
<td>Annual Review, approved June 1, 2021. Policy updated with literature review through February 24, 2021; references added. Investigational policy statement edited for clarity. Policy statements otherwise unchanged.</td>
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<tr>
<td>07/01/22</td>
<td>Annual Review, approved June 13, 2022. Policy updated with literature review through February 21, 2022; references updated. Policy statements unchanged. Added CPT codes 0200T and 0201T.</td>
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<tr>
<td>01/01/23</td>
<td>Coding update. Added new HCPC codes C7504 and C7505.</td>
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<tr>
<td>07/01/23</td>
<td>Annual Review, approved June 12, 2023. Policy updated with literature review through March 6, 2023; references updated. Policy statements unchanged. Changed the wording from &quot;patient&quot; to &quot;individual&quot; throughout the policy for standardization.</td>
</tr>
</tbody>
</table>

**Disclaimer:** This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply. CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). ©2023 Premera All Rights Reserved.

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Alaska residents: Contact the Alaska Division of Insurance via email at insurance@alaska.gov, or by phone at 907-269-7900 or 1-800-INSURAK (in-state, outside Anchorage).

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-722-1471 (TTY: 711).


注意事項：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-722-1471 (TTY: 711)。

УВАГА!: Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Тел. 800-722-1471 (телетайп: 711).

ЛУС ЦЕЕВ: Yог тияс кой хисл нглубо, ков ков паб хокс лус, манж ков паб дабв ро кой. Нгу ро 800-722-1471 (TTY: 711).

MO LOU SILAFIA: Afaí e te tautala Gagana fa'a Sāmoa, o fa'e tua auaana foa feafoa, e fa'i fua e leai se topoto, mo oe, Telefonia ma: 800-722-1471 (TTY: 711).

ПАКААР: Нераита ки ти олоко, ти серисю пари ти баддюнг ти линггуву нга аванан бадынан, кет сидадаан пе каренан. Араан 800-722-1471 (TTY: 711).

Language Assistance (in-state, outside Anchorage): Contact the Alaska Division of Insurance via email at insurance@alaska.gov, or by phone at 907-269-7900 or 1-800-INSURAK (in-state, outside Anchorage).