LCD Reference Article	Billing and Coding Article

Article - Billing and Coding: Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF) (A57752)

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Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATES
Novitas Solutions, Inc.	A and B MAC	04111 - MAC A	J - H	Colorado
Novitas Solutions, Inc.	A and B MAC	04112 - MAC B	J - H	Colorado
Novitas Solutions, Inc.	A and B MAC	04211 - MAC A	J - H	New Mexico
Novitas Solutions, Inc.	A and B MAC	04212 - MAC B	J - H	New Mexico
Novitas Solutions, Inc.	A and B MAC	04311 - MAC A	J - H	Oklahoma
Novitas Solutions, Inc.	A and B MAC	04312 - MAC B	J - H	Oklahoma
Novitas Solutions, Inc.	A and B MAC	04411 - MAC A	J - H	Texas
Novitas Solutions, Inc.	A and B MAC	04412 - MAC B	J - H	Texas
Novitas Solutions, Inc.	A and B MAC	04911 - MAC A	J - H	Colorado New Mexico Oklahoma Texas
Novitas Solutions, Inc.	A and B MAC	07101 - MAC A	J - H	Arkansas
Novitas Solutions, Inc.	A and B MAC	07102 - MAC B	J - H	Arkansas
Novitas Solutions, Inc.	A and B MAC	07201 - MAC A	J - H	Louisiana
Novitas Solutions, Inc.	A and B MAC	07202 - MAC B	J - H	Louisiana
Novitas Solutions, Inc.	A and B MAC	07301 - MAC A	J - H	Mississippi
Novitas Solutions, Inc.	A and B MAC	07302 - MAC B	J - H	Mississippi
Novitas Solutions, Inc.	A and B MAC	12101 - MAC A	J - L	Delaware
Novitas Solutions, Inc.	A and B MAC	12102 - MAC B	J - L	Delaware
Novitas Solutions, Inc.	A and B MAC	12201 - MAC A	J - L	District of Columbia
Novitas Solutions, Inc.	A and B MAC	12202 - MAC B	J - L	District of Columbia
Novitas Solutions, Inc.	A and B MAC	12301 - MAC A	J - L	Maryland
Novitas Solutions, Inc.	A and B MAC	12302 - MAC B	J - L	Maryland
Novitas Solutions, Inc.	A and B MAC	12401 - MAC A	J - L	New Jersey
Novitas Solutions, Inc.	A and B MAC	12402 - MAC B	J - L	New Jersey
Novitas Solutions, Inc.	A and B MAC	12501 - MAC A	J - L	Pennsylvania

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATES
Novitas Solutions, Inc.	A and B MAC	12502 - MAC B	J - L	Pennsylvania
Novitas Solutions, Inc.	A and B MAC	12901 - MAC A	J - L	Delaware District of Columbia Maryland New Jersey Pennsylvania

Article Information

General Information

Article ID
A57752

Article Title
Billing and Coding: Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF)

Article Type
Billing and Coding

Original Effective Date
11/21/2019

Revision Effective Date
07/12/2020

Revision Ending Date
N/A

Retirement Date
N/A

CMS National Coverage Policy

Internet Only Manuals (IOMs)

- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*,
    - Chapter 23, Section 20.9 National Correct Coding Initiative (NCCI)
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*,
    - Chapter 30, Section 50 Form CMS-R-131 Advance beneficiary Notice of Noncoverage (ABN)

Social Security Act (Title XVIII) Standard References:

- Title XVIII of the Social Security Act, Section 1833(e) states that no payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period.

Article Guidance

Article Text

This Billing and Coding Article provides billing and coding guidance for Local Coverage Determination (LCD) L35130 (Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF). Please refer to the LCD for reasonable and necessary requirements.

Coding Guidance

Notice: It is not appropriate to bill Medicare for services that are not covered (as described by the entire LCD) as if they are covered. When billing for non-covered services, use the appropriate modifier.

Documentation Requirements

1. All documentation must be maintained in the patient's medical record and made available to the contractor upon request.
2. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service[s]). The documentation must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient.
3. The submitted medical record must support the use of the selected ICD-10-CM code(s). The submitted CPT/HCPCS code must describe the service performed.

Coding Information

1. Percutaneous vertebral augmentation including cavity creation using mechanical device of one vertebral body must be reported with CPT codes 22513 (thoracic), 22514 (lumbar) and 22515 (each additional thoracic or lumbar vertebral body [list separately in addition to code for the primary procedure]).
2. Modifiers 50, LT/RT are not required for CPT codes 22510, 22511, 22512, 22513, 22514, and 22515. The CPT descriptor is per vertebral body, unilateral or bilateral.
3. Standard payment adjustment rules for multiple procedures will apply if performed at more than one level on the same date of service.
4. Bone biopsy is considered integral to both percutaneous vertebroplasty and percutaneous vertebral augmentation procedures and should not be billed separately unless the biopsy is at a different site or performed during a different session.
5. If bone biopsy is performed on a separate site, modifier 59 or modifier XS – Separate Structure, must be

reported with the CPT code submitted and documentation must clearly support a separate and distinct procedure from the procedure performed. Identify the site (such as L1) in the item 19 of the CMS 1500 form or its electronic equivalent.

6. Payment of vertebroplasty and vertebral augmentation will be all-inclusive for the entire procedure (i.e. injection, intraosseous venography, etc.).
7. No separate payment for venography performed during the operative session may be allowed and it should not be separately billed.
8. The "assistant at surgery" Medicare Physician Fee Schedule Database indicator for percutaneous vertebroplasty and percutaneous vertebral augmentation (kyphoplasty) procedures is "1." Therefore, a statutory payment restriction for assistants at surgery applies to this procedure and an assistant at surgery may not be paid.

For services requiring a referring/ordering physician, the name and NPI of the referring/ordering physician must be reported on the claim.

The diagnosis code(s) must best describe the patient's condition for which the service was performed.

An Advance Beneficiary Notice of Noncoverage (ABN) may be used for services which are likely to be non-covered, whether for medical necessity or for other reasons. Refer to CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 30, for complete instructions.

All services/procedures performed on the same day for the same beneficiary by the physician/provider should be billed on the same claim.

Coding Information

CPT/HCPCS Codes

Group 1 Paragraph:

Note: Providers are reminded to refer to the long descriptors of the CPT codes in their CPT book.

Group 1 Codes: (6 Codes)

CODE	DESCRIPTION
22510	Perq cervicothoracic inject
22511	Perq lumbosacral injection
22512	Vertebroplasty addl inject
22513	Perq vertebral augmentation
22514	Perq vertebral augmentation
22515	Perq vertebral augmentation

CPT/HCPCS Modifiers

Group 1 Paragraph:

N/A

Group 1 Codes:

N/A

ICD-10-CM Codes that Support Medical Necessity

Group 1 Paragraph:

It is the provider's responsibility to select codes carried out to the highest level of specificity and selected from the ICD-10-CM code book appropriate to the year in which the service is rendered for the claim(s) submitted.

Medicare is establishing the following limited coverage for **CPT/HCPCS codes: 22510, 22511, 22512, 22513, 22514, and 22515** for **Osteoporotic Vertebral Fractures.**

Covered for:

Group 1 Codes: (4 Codes)

CODE	DESCRIPTION
M80.08XA	Age-related osteoporosis with current pathological fracture, vertebra(e), initial encounter for fracture
M80.08XS	Age-related osteoporosis with current pathological fracture, vertebra(e), sequela
M80.88XA	Other osteoporosis with current pathological fracture, vertebra(e), initial encounter for fracture
M80.88XS	Other osteoporosis with current pathological fracture, vertebra(e), sequela

Group 2 Paragraph:

It is the provider's responsibility to select codes carried out to the highest level of specificity and selected from the ICD-10-CM code book appropriate to the year in which the service is rendered for the claim(s) submitted.

The following ICD-10-CM codes support medical necessity and provide coverage for (CPT/HCPCS) codes: **22510, 22511, 22512, 22513, 22514 and 22515 for Malignant Fractures.**

Group 2 Codes: (2 Codes)

CODE	DESCRIPTION
M84.58XA*	Pathological fracture in neoplastic disease, other specified site, initial encounter for fracture
M84.58XS*	Pathological fracture in neoplastic disease, other specified site, sequela

Group 2 Medical Necessity ICD-10-CM Codes Asterisk Explanation:

*****Dual Diagnosis Requirement – M84.58XA or M84.58XS must be reported with either C41.2, C79.51, C79.52,

C90.00, C90.01 or C90.02.

ICD-10-CM Codes that DO NOT Support Medical Necessity

Group 1 Paragraph:

All those not listed under the "ICD-10 Codes that Support Medical Necessity" section of this policy.

Group 1 Codes: (1 Code)

CODE	DESCRIPTION
XX000	Not Applicable

ICD-10-PCS Codes

N/A

Additional ICD-10 Information

N/A

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 article does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the article should be assumed to apply equally to all claims.

CODE	DESCRIPTION
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 article, 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 article should be assumed to apply equally to all Revenue Codes.

CODE	DESCRIPTION
99999	Not Applicable

Other Coding Information

N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
07/12/2020	R6	Article revised and published 2/17/2022 to indicate that the Revision History Explanation (R5) below contains a typographical error in the second sentence. The second sentence should read as follows: Diagnosis codes C41.2, C79.51, C79.52, C90.00, **C90.01** and C90.02 have been removed from the ICD-10-CM group 2 table.
07/12/2020	R5	Article revised and published on 01/27/2022 to add an asterisk to M84.58XA and M84.58XS in ICD-10-CM code group 2. Diagnosis codes C41.2, C79.51, C79.52, C90.00, C90.02 and C90.02 have been removed from the ICD-10-CM group 2 table. The Group 2 Medical Necessity ICD-10-CM Codes Asterisk Explanation was revised to state "Dual Diagnosis Requirement – M84.58XA or M84.58XS must be reported with either C41.2, C79.51, C79.52, C90.00, C90.01 or C90.02. Revisions are in response to an internal request from appeals.
07/12/2020	R4	Article updated on 02/02/2021 for administrative purposes. No changes have been made to the Article content.
07/12/2020	R3	Article updated on 05/29/2020 for administrative purposes. No changes have been made to the Article content.
07/12/2020	R2	Future billing and coding article related to L35130, Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF) published on 05/28/2020 and will become effective on 07/12/2020.
07/12/2020	R1	Future billing and coding article related to L35130, Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF) published on 05/28/2020 and will become effective on 07/12/2020.

Associated Documents

Related Local Coverage Documents

Articles

DA57752 - (MCD Archive Site)

A58195 - Response to Comments: Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture

(VCF)

LCDs

DL35130 - (MCD Archive Site)

L35130 - Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF)

Related National Coverage Documents

N/A

Statutory Requirements URLs

N/A

Rules and Regulations URLs

N/A

CMS Manual Explanations URLs

N/A

Other URLs

N/A

Public Versions

UPDATED ON	EFFECTIVE DATES	STATUS
Some older versions have been archived. Please visit the MCD Archive Site to retrieve them.		
02/11/2022	07/12/2020 - N/A	Currently in Effect (This Version)
01/21/2022	07/12/2020 - N/A	Superseded
05/27/2021	07/12/2020 - N/A	Superseded
05/29/2020	07/12/2020 - N/A	Superseded
05/22/2020	07/12/2020 - N/A	Superseded

Keywords

N/A