Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines:

Vertebroplasty and Kyphoplasty

Effective: July 1, 2026

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request to the FAX numbers below.	Yes ☒ No ☐
Notification Required IF REQUIRED, concurrent review may apply	Yes ☐ No ☒

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products; 800-232-0816
☒ Tufts Health Plan Commercial products; 617-972-9409

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); 888-415-9055
☒ Tufts Health Together – MassHealth Accountable Care Partnership Plans; 888-415-9055
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; 857-304-6404
☒ Tufts Health One Care – A dual-eligible product; 857-304-6304

Senior Products

☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); 617-972-9409
☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); 617-972-9409
☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); 617-972-9409

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

For Harvard Pilgrim Health Care Members:

This policy utilizes InterQual® criteria and/or tools, which Harvard Pilgrim may have customized. You may request authorization and complete the automated authorization questionnaire via HPHConnect at www.harvardpilgrim.org/providerportal. In some cases, clinical documentation may be required to complete a medical necessity review. Please submit required documentation as follows:

- Clinical notes/written documentation – via HPHConnect Clinical Upload or secure fax (800-232-0816)

Providers may view and print the medical necessity criteria and questionnaire via HPHConnect for providers (Select Researched and the InterQual® link) or contact the commercial Provider Service Center at 800-708-4414. (To register for HPHConnect, follow the instructions here). Members may access materials by logging into their online account (visit www.harvardpilgrim.org, click on Member Login, then Plan Details, Prior Authorization for Care, and the link to clinical criteria) or by calling Member Services at 888-333-4742.

For Tufts Health Plan Members:

To obtain InterQual® SmartSheets™"

- **Tufts Health Plan Commercial Plan products:** If you are a registered Tufts Health Plan provider click here to access the Provider Website. If you are not a Tufts Health Plan provider, please click on the Provider Log-in and follow instructions to register on the Provider website or call Provider Services at 888.884.2404
- **Tufts Health Public Plans products:** InterQual® SmartSheet(s) available as part of the prior authorization process

Tufts Health Plan requires the use of current InterQual® Smartsheet(s) to obtain prior authorization.

In order to obtain prior authorization for procedure(s), choose the appropriate InterQual® SmartSheet(s) listed below. The completed SmartSheet(s) must be sent to the applicable fax number indicated above, according to Plan

Overview

Percutaneous vertebroplasty and kyphoplasty are used for the treatment of osteoporotic compression fractures, painful vertebral hemangiomas, myeloma, and metastatic lesions. Both procedures involve the injection of bone cement under image guidance into the spinal fractures with the goal of relieving pain, improving mobility, and preventing further collapse of the bone. For kyphoplasty, a low-pressure cavity is created in the fractured vertebral body by placement of an inflatable bone tamps. Bone cement is placed into this cavity to reduce the fracture and to possibly improve the kyphotic deformity.

The Plan uses guidance from the Centers for Medicare and Medicaid Services (CMS) and MassHealth for coverage determinations for its Dual Product Eligible plan members. CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and documentation included in the Medicare manuals and MassHealth Medical Necessity Determinations are the basis for coverage determinations. LCD - Percutaneous Vertebral Augmentation (PVA) for Osteoporotic Vertebral Compression Fracture (VCF) (L33569) (cms.gov) is being supplemented using InterQual to provide additional detail regarding medical necessity criteria.

For the service of Vertebroplasty and kyphoplasty, evidence is sufficient for coverage. In addition to the coverage of vertebroplasty or kyphoplasty for osteoporotic vertebral compression factures, InterQual provides guidance for the use of Vertebroplasty or kyphoplasty for various indications. The guidance for the use of this expanded criteria for these indications is supported clinical research and evidence-based medicine.

The use of this criteria in the utilization management process will ensure access to evidence based clinically appropriate care. See References section below for all evidence accessed in the development of these criteria.

Clinical Guideline Coverage Criteria

The Plan requires the use of the following InterQual® Subsets or SmartSheets to obtain prior authorization for vertebroplasty or kyphoplasty:

1. Vertebroplasty
2. Kyphoplasty

Codes

The following code(s) require prior authorization:

Table 1: CPT/HCPCS Codes

Code	Description
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)

References:

1. Feng F, Tang H, Chen H, Jia P, Bao L, Li JJ. Percutaneous vertebroplasty for Langerhans cell histiocytosis of the lumbar spine in an adult: Case report and review of the literature. Exp Ther Med. 2013 Jan;5(1):128-132. doi:

10.3892/etm.2012.791. Epub 2012 Nov 1. PMID: 23251253; PMCID: PMC3524240.
2. Piper K, Zou L, Li D, et al. Surgical Management and Adjuvant Therapy for Patients With Neurological Deficits From Vertebral Hemangiomas: A Meta-Analysis. Spine (Phila Pa 1976). 2020;45(2):E99-E110. doi:10.1097/BRS.0000000000003181
3. Wang B, Han SB, Jiang L, et al. Intraoperative vertebroplasty during surgical decompression and instrumentation for aggressive vertebral hemangiomas: a retrospective study of 39 patients and review of the literature. Spine J. 2018;18(7):1128-1135. doi:10.1016/j.spinee.2017.11.003

Approval And Revision History

October 20, 2020: Reviewed by the Medical Policy Approval Committee (MPAC) as a new policy effective January 1, 2021

Subsequent endorsement date(s) and changes made:

- November 17, 2021: Reviewed by MPAC with no changes
- July 20, 2022: Reviewed by MPAC for integration between Harvard Pilgrim Health Care and Tufts Health Plan; InterQual criteria adopted effective September 1, 2022
- June 21, 22: Reviewed by MPAC with no changes, effective August 1, 2023
- November 16, 2023: Reviewed by MPAC, renewed without changes
- November 2023: Rebranded Unify to One Care and updated overview, effective January 1, 2024
- December 1, 2023: Reviewed and approved by UM Committee, effective January 1, 2024
- June 13, 2024: Reviewed and approved by UM Committee, effective July 1, 2024
- June 20, 2024: Reviewed by MPAC for 2024 InterQual upgrade, effective July 1, 2024
- November 21, 2024: Reviewed by MPAC, renewed without changes, effective January 1, 2025
- December 13, 2024: Reviewed and approved by the UM Committee, effective January 1, 2025
- May 21, 2025: Reviewed by MPAC for 2025 InterQual Update effective July 1, 2025
- July 3, 2025: Harvard Pilgrim Health Care Stride Medicare Advantage removed as an applicable product from the template
- November 19, 2025: Reviewed by MPAC for annual review, renewed without changes effective January 1, 2026
- December 8, 2025: Reviewed by UM Committee for annual review, renewed without changes effective January 1, 2026
- May 20, 2026: Reviewed by MPAC for 2026 InterQual Update, effective July 1, 2026

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.