Percutaneous Vertebroplasty and Kyphoplasty

Clinical Coverage Criteria

Overview

Fallon Health utilizes InterQual® Clinical Criteria for this policy as of 05/01/2014. This criteria can be accessed via Mckesson.

Policy History

Origination date:	05/01/2014
Approval(s):	Technology Assessment Committee 12/18/2013 (Adopted Interqual Criteria) 01/28/2015 (annual review), 01/27/2016 (annual review), 01/25/2017 (annual review), 01/24/2018) (annual review), 01/23/2019 (annual review)

Not all services mentioned in this policy are covered for all products or employer groups. Coverage is based upon the terms of a member's particular benefit plan which may contain its own specific provisions for coverage and exclusions regardless of medical necessity. Please consult the product's Evidence of Coverage for exclusions or other benefit limitations applicable to this service or supply. If there is any discrepancy between this policy and a member's benefit plan, the provisions of the benefit plan will govern. However, applicable state mandates take precedence with respect to fully-insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, federal mandates will apply to all plans. For Medicare and Medicaid members, this policy will apply unless Medicare and Medicaid policies extend coverage beyond this policy.