

Balloon Kyphoplasty and Vertebroplasty

Medicare Local Coverage Determination (LCD) and Billing and Coding resource

This document contains a sample checklist specifically designed for each Medicare Administrative Contractor (MAC) to support patient access to these procedures. This tool is based on the active LCD and Billing and Coding articles for Percutaneous Vertebral Augmentation (PVA) for vertebral compression fracture.

MAC	States
CGS	KY, OH
FCSO	FL, PR, VI
NGS	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI
Noridian	J-E: AS, CA, GU, HI, MP, NV J-F: AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY
Novitas	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX
Palmetto	AL, GA, NC, SC, TN, VA, WV
WPS	IA, IN, KS, MI, MO, NE

Medtronic provides this information for your convenience only. It does not constitute legal advice or a recommendation regarding clinical practice. Information provided is gathered from third-party sources and is subject to change without notice due to frequently changing laws, rules and regulations. The provider has the responsibility to determine medical necessity and to submit appropriate codes and charges for care provided. Medtronic makes no guarantee that the use of this information will prevent differences of opinion or disputes with Medicare or other payers as to the correct form of billing or the amount that will be paid to providers of service. Please contact your Medicare contractor, other payers, reimbursement specialists and/or legal counsel for interpretation of coding, coverage and payment policies. This document provides assistance for FDA approved or cleared indications. Where reimbursement is sought for use of a product that may be inconsistent with, or not expressly specified in, the FDA cleared or approved labeling (e.g. instructions for use, operator's manual or package insert), consult with your billing advisors or payers on handling such billing issues. Some payers may have policies that make it inappropriate to submit claims for such items or related service.

Medicare (CGS) Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF)

KY, OH

coverage indications, limitations, and/or medical necessity

PVA (percutaneous vertebroplasty (PVP) or kyphoplasty (PKP)) is covered in patients who qualify based on the following criteria:

all of the following

- acute (<6 weeks) or subacute (6-12 weeks) osteoporotic VCF (T1 – L5)
- by recent (within 30 days) advanced imaging (bone marrow edema on MRI or bone-scan/ SPECT/CT uptake)
- all patients presenting with VCF should be referred for evaluation of BMD and osteoporosis education for subsequent treatment as indicated and instructed to take part in an osteoporosis prevention/ treatment program

+ one of the following

- symptomatic and is hospitalized with severe pain (NRS or VAS pain score ≥ 8) or
- symptomatic and non-hospitalized with moderate to severe pain (NRS or VAS ≥ 5) despite optimal non-surgical management (NSM) + worsening pain or
- symptomatic and non-hospitalized with moderate to severe pain (NRS or VAS ≥ 5) despite optimal non-surgical management (NSM) + stable to improved pain (but NRS or VAS ≥ 5) when 2 or more of the following are present:
 - progression of vertebral body height loss
 - $> 25\%$ vertebral body height reduction
 - kyphotic deformity
 - severe impact of VCF on daily functioning (Roland Morris Disability Questionnaire (RDQ) >17)

malignant vertebral fractures

Vertebral augmentation and Kyphoplasty for vertebral compression fractures with intractable spinal pain secondary not relieved with medical therapy will be covered for osteolytic vertebral metastatic disease or myeloma involving a vertebral body.

exclusion criteria

absolute contraindication

- current back pain is not primarily due to the identified acute or subacute VCF(s)
- osteomyelitis, discitis or active systemic or surgical site infection
- pregnancy

relative contraindication

- greater than three vertebral fractures
- allergy to bone cement or opacification agents
- uncorrected coagulopathy
- spinal instability
- myelopathy from the fracture
- neurologic deficit
- neural impingement
- fracture retropulsion / canal compromise

CPT codes for percutaneous vertebral augmentation

22510, 22511, 22512, 22513, 22514, 22515

ICD-10 diagnosis codes that support medical necessity

As specified in [CGS Local Coverage Article \(LCA\) A57282](#). Access LCA for code descriptions.

group 1 codes

M80.08XA M80.88XA

group 2 codes

C41.2*	C79.51*	C90.00*
C90.02*	M84.58XA	M84.58XS

Codes with an * must be reported with either M84.58XA or M84.58XS



Questions

[Email: neuro.us.reimbursement@medtronic.com](mailto:neuro.us.reimbursement@medtronic.com)

Resources

[CGS Local Coverage Determination \(LCD\) L38201](#)
[CGS Local Coverage Article \(LCA\) A57282](#)

Medicare (FCSO) Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF)

FL, PR, VI

coverage indications, limitations, and/or medical necessity

Percutaneous vertebroplasty and percutaneous vertebral augmentation (PVA or Kyphoplasty) procedures will be considered medically reasonable and necessary for the following indications: Painful, debilitating, osteoporotic vertebral collapse/compression fractures, defined as those that have not responded to non-surgical medical management (e.g., narcotic and/or non-narcotic medication, physical therapy modalities) with and without methods of immobility (e.g., rest, bracing). Both Percutaneous Vertebroplasty (PVP) and Percutaneous Vertebral Augmentation (PVA) will be considered reasonable and necessary when all of the following criteria are met:

all of the following

- acute (<6 weeks) or subacute (6-12 weeks) osteoporotic VCF (T1 - L5) based on symptom onset
- documented by advanced imaging demonstrating bone marrow edema on MRI or bone-scan/ SPECT/CT uptake
- all patients presenting with VCF should be referred for evaluation of BMD and osteoporosis education for subsequent treatment as indicated and instructed to take part in an osteoporosis prevention/ treatment program

+ one of the following

- symptomatic and is hospitalized with severe pain (NRS or VAS pain score ≥ 8) or
- non-hospitalized with moderate to severe pain (NRS or VAS ≥ 5) despite optimal non-surgical management (NSM) + worsening pain or
- non-hospitalized with moderate to severe pain (NRS or VAS ≥ 5) despite optimal non-surgical management (NSM) + stable to improved pain (but NRS or VAS ≥ 5) when 2 or more of the following are present:
 - progression of vertebral body height loss
 - $> 25\%$ vertebral body height reduction
 - kyphotic deformity
 - severe impact of VCF on daily functioning (Roland Morris Disability Questionnaire (RDQ) > 17)

malignant vertebral fractures

Osteolytic vertebral metastasis or myeloma with severe back pain related to a destruction of the vertebral body, not involving the major part of the cortical bone.

exclusion criteria

absolute contraindication

- current back pain is not primarily due to the identified acute or subacute VCF(s)
- osteomyelitis, discitis or active systemic infection
- pregnancy
- active surgical site infection

relative contraindication

- greater than three vertebral fractures per procedure
- allergy to bone cement or opacification agents
- uncorrected coagulopathy
- spinal instability
- myelopathy from the fracture
- neurologic deficit
- neural impingement
- fracture retropulsion / canal compromise

CPT codes for percutaneous vertebral augmentation

22510, 22511, 22512, 22513, 22514, 22515

ICD-10 diagnosis codes that support medical necessity

As specified in [FCSO Local Coverage Article \(LCA\) A57872](#). Access LCA for code descriptions.

group 1 codes

M80.08XA M80.08XS M80.88XA M80.88XS

group 2 codes

M84.58XA* M84.58XS*

*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



Questions

[Email: neuro.us.reimbursement@medtronic.com](mailto:neuro.us.reimbursement@medtronic.com)

Resources

[FCSO Local Coverage Determination \(LCD\) L34976](#)
[FCSO Local Coverage Article \(LCA\) A57872](#)

Medicare (NGS) Percutaneous Vertebral Augmentation (PVA) for Osteoporotic Vertebral Compression Fracture (VCF)

CT, IL, MA, ME, MN, NH, NY, RI, VT, WI

coverage indications, limitations, and/or medical necessity

Provisions in this LCD and related coding article only address Vertebral Augmentation for Osteoporotic VCF. Coverage will remain available for medically necessary procedures for other conditions not included in this LCD. PVA (percutaneous vertebroplasty (PVP) or kyphoplasty (PKP)) is covered in patients who qualify based on the following criteria:

all of the following

- acute (<6 weeks) or subacute (6-12 weeks) osteoporotic VCF (T1 - L5) based on symptom onset
- documented by advanced imaging (bone marrow edema on MRI or bone-scan/SPECT/CT uptake)
- all patients presenting with VCF should be referred for evaluation of BMD and osteoporosis education for subsequent treatment as indicated and instructed to take part in an osteoporosis prevention/ treatment program

+ one of the following

- symptomatic and is hospitalized with severe pain (NRS or VAS pain score ≥ 8) or
- symptomatic and non-hospitalized with moderate to severe pain (NRS or VAS ≥ 5) despite optimal non-surgical management (NSM) + worsening pain or
- symptomatic and non-hospitalized with moderate to severe pain (NRS or VAS ≥ 5) despite optimal non-surgical management (NSM) + stable to improved pain (but NRS or VAS ≥ 5) when 2 or more of the following are present:
 - progression of vertebral body height loss
 - $> 25\%$ vertebral body height reduction
 - kyphotic deformity
 - severe impact of VCF on daily functioning (Roland Morris Disability Questionnaire (RDQ) >17)

exclusion criteria

absolute contraindication

- current back pain is not primarily due to the identified acute or subacute VCF(s)
- osteomyelitis, discitis, active systemic or surgical site infection
- pregnancy

relative contraindication

- greater than three vertebral fractures per procedure
- allergy to bone cement or opacification agents
- uncorrected coagulopathy
- spinal instability
- myelopathy from the fracture
- neurologic deficit
- neural impingement
- fracture retropulsion / canal compromise

CPT codes for percutaneous vertebral augmentation

22510, 22511, 22512, 22513, 22514, 22515

ICD-10 diagnosis codes that support medical necessity

As specified in [NGS Local Coverage Article \(LCA\) A56178](#). Access LCA for code descriptions.

group 1 codes

M80.08XA M80.08XS M80.88XA M80.88XS



Questions

[Email: neuro.us.reimbursement@medtronic.com](mailto:neuro.us.reimbursement@medtronic.com)

Resources

[NGS Local Coverage Determination \(LCD\) L33569](#)
[NGS Local Coverage Article \(LCA\) A56178](#)

Medicare (Noridian) Percutaneous Vertebral Augmentation (PVA) for Osteoporotic Vertebral Compression Fracture (VCF)

J-E: AS, CA, GU, HI, MP, NV

J-F: AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY

coverage indications, limitations, and/or medical necessity

Provisions in this LCD and related coding article only address Vertebral Augmentation for Osteoporotic Vertebral Compression Fracture (VCF). Coverage will remain available for medically necessary procedures for other conditions not included in this LCD. PVA (percutaneous vertebroplasty (PVP) or kyphoplasty (PKP)) is covered in patients who qualify based on the following criteria:

all of the following

- acute (<6 weeks) or subacute (6-12 weeks) osteoporotic VCF (T1 - L5) based on symptom onset
- documented by advanced imaging (bone marrow edema on MRI or bone-scan/SPECT/CT uptake)
- all patients presenting with VCF should be referred for evaluation of BMD and osteoporosis education for subsequent treatment as indicated and instructed to take part in an osteoporosis prevention/ treatment program

+ one of the following

- symptomatic and is hospitalized with severe pain (NRS or VAS pain score ≥ 8) or
- symptomatic and non-hospitalized with moderate to severe pain (NRS or VAS ≥ 5) despite optimal non-surgical management (NSM) + worsening pain or
- symptomatic and non-hospitalized with moderate to severe pain (NRS or VAS ≥ 5) despite optimal non-surgical management (NSM) + stable to improved pain (but NRS or VAS ≥ 5) when 2 or more of the following are present:
 - progression of vertebral body height loss
 - $> 25\%$ vertebral body height reduction
 - kyphotic deformity
 - severe impact of VCF on daily functioning (Roland Morris Disability Questionnaire (RDQ) >17)

exclusion criteria

absolute contraindication

- current back pain is not primarily due to the identified acute or subacute VCF(s)
- osteomyelitis, discitis or active systemic or surgical site infection
- pregnancy

relative contraindication

- greater than three vertebral fractures per procedure
- allergy to bone cement or opacification agents
- uncorrected coagulopathy
- spinal instability
- myelopathy from the fracture
- neurologic deficit
- neural impingement
- fracture retropulsion / canal compromise

CPT codes for percutaneous vertebral augmentation

22510, 22511, 22512, 22513, 22514, 22515

ICD-10 diagnosis codes that support medical necessity

As specified in [Noridian Local Coverage Article \(LCA\) A56572](#) Access LCA for code descriptions.

group 1 codes

M80.08XA M80.08XS M80.88XA M80.88XS

group 2 codes

C41.2*	C79.51*	C79.52*	C90.00*
C90.01*	C90.02*	M84.58XA	M84.58XS

* Two diagnosis codes must be reported for Group 2. M84.58XA or M84.58XS must be reported in addition to one of the CXX.XX diagnosis codes listed.



Questions

[Email: neuro.us.reimbursement@medtronic.com](mailto:neuro.us.reimbursement@medtronic.com)

Resources

[Noridian Local Coverage Determination \(LCD\) L34228](#)
[Noridian Local Coverage Article \(LCA\) A56572](#)

Medicare (Novitas) Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF)

AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX

coverage indications, limitations, and/or medical necessity

Percutaneous vertebroplasty and percutaneous vertebral augmentation (PVA or Kyphoplasty) procedures will be considered medically reasonable and necessary for the following indications: Painful, debilitating, osteoporotic vertebral collapse/compression fractures, defined as those that have not responded to non-surgical medical management (e.g., narcotic and/or non-narcotic medication, physical therapy modalities) with and without methods of immobility (e.g., rest, bracing). Both Percutaneous Vertebroplasty (PVP) and PVA will be considered reasonable and necessary when all of the following criteria are met:

all of the following

- acute (<6 weeks) or subacute (6-12 weeks) osteoporotic VCF (T1 - L5) based on symptom onset
- documented by advanced imaging (bone marrow edema on MRI or bone-scan/SPECT/CT uptake)
- all patients presenting with VCF should be referred for evaluation of BMD and osteoporosis education for subsequent treatment as indicated and instructed to take part in an osteoporosis prevention/ treatment program

+ one of the following

- symptomatic and is hospitalized with severe pain (NRS or VAS pain score ≥ 8) or
- non-hospitalized with moderate to severe pain (NRS or VAS ≥ 5) despite optimal non-surgical management (NSM) + worsening pain or
- non-hospitalized with moderate to severe pain (NRS or VAS ≥ 5) despite optimal non-surgical management (NSM) + stable to improved pain (but NRS or VAS ≥ 5) when 2 or more of the following are present:
 - progression of vertebral body height loss
 - $> 25\%$ vertebral body height reduction
 - kyphotic deformity
 - severe impact of VCF on daily functioning (Roland Morris Disability Questionnaire (RDQ) > 17)

malignant vertebral fractures

Osteolytic vertebral metastasis or myeloma with severe back pain related to a destruction of the vertebral body, not involving the major part of the cortical bone.

exclusion criteria

absolute contraindication

- current back pain is not primarily due to the identified acute or subacute VCF(s)
- osteomyelitis, discitis or active systemic infection
- pregnancy
- active surgical site infection

relative contraindication

- greater than three vertebral fractures per procedure
- allergy to bone cement or opacification agents
- uncorrected coagulopathy
- spinal instability
- myelopathy from the fracture
- neurologic deficit
- neural impingement
- fracture retropulsion / canal compromise

CPT codes for percutaneous vertebral augmentation

22510, 22511, 22512, 22513, 22514, 22515

ICD-10 diagnosis codes that support medical necessity

As specified in [Novitas Local Coverage Article \(LCA\) A57752](#). Access LCA for code descriptions.

group 1 codes

M80.08XA M80.08XS M80.88XA M80.88XS

group 2 codes

M84.58XA* M84.58XS*

* 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



Questions

[Email: neuro.us.reimbursement@medtronic.com](mailto:neuro.us.reimbursement@medtronic.com)

Resources

[Novitas Local Coverage Determination \(LCD\) L35130](#)
[Novitas Local Coverage Article \(LCA\) A57752](#)

Medicare (**Palmetto**) Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF)

AL, GA, NC, SC, TN, VA, WV

coverage indications, limitations, and/or medical necessity

PVA (percutaneous vertebroplasty (PVP) or kyphoplasty (PKP)) is covered in patients who qualify based on the following criteria:

all of the following

- acute (<6 weeks) or subacute (6-12 weeks) osteoporotic VCF (T1 – L5)
- recent (within 30 days) advanced imaging (bone marrow edema on MRI or bone-scan/ SPECT/CT uptake)
- all patients presenting with VCF should be referred for evaluation of BMD and osteoporosis education for subsequent treatment as indicated and instructed to take part in an osteoporosis prevention/ treatment program

+ one of the following

- symptomatic and is hospitalized with severe pain (NRS or VAS pain score ≥ 8) or
- symptomatic and non-hospitalized with moderate to severe pain (NRS or VAS ≥ 5) despite optimal non-surgical management (NSM) + worsening pain or
- symptomatic and non-hospitalized with moderate to severe pain (NRS or VAS ≥ 5) despite optimal non-surgical management (NSM) + stable to improved pain (but NRS or VAS ≥ 5) when 2 or more of the following are present:
 - progression of vertebral body height loss
 - $> 25\%$ vertebral body height reduction
 - kyphotic deformity
 - severe impact of VCF on daily functioning (Roland Morris Disability Questionnaire (RDQ) >17)

* consider including pedicle periosteal infiltration

malignant vertebral fractures

Vertebral augmentation and kyphoplasty for vertebral compression fractures with intractable spinal pain not relieved with medical therapy will be covered for osteolytic vertebral metastatic disease or myeloma involving a vertebral body.

exclusion criteria

absolute contraindication

- current back pain is not primarily due to the identified acute or subacute VCF(s)
- osteomyelitis, discitis or active systemic or surgical site infection
- pregnancy

relative contraindication

○ allergy to bone cement or opacification agents	○ neurologic deficit
○ uncorrected coagulopathy	○ neural impingement
○ spinal instability	○ fracture retropulsion / canal compromise
○ myelopathy from the fracture	○ greater than three vertebral fractures

CPT codes for percutaneous vertebral augmentation

22510, 22511, 22512, 22513, 22514, 22515

ICD-10 diagnosis codes that support medical necessity

As specified in [Palmetto Local Coverage Article \(LCA\) A58275](#). Access LCA for code descriptions.

group 1 codes

M80.08XA M80.08XG M80.08XK M80.08XP M80.08XS M80.88XA M80.88XS

group 2 codes

C41.2* C79.51* C90.00* C90.02* M84.58XA M84.58XS

codes with an (*) must be reported with either M84.58XA or M84.58XS



Questions

[Email: neuro.us.reimbursement@medtronic.com](mailto:neuro.us.reimbursement@medtronic.com)

Resources

[Palmetto Local Coverage Determination \(LCD\) L38737](#)

[Palmetto Local Coverage Article \(LCA\) A58275](#)

Medicare (WPS) Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF)

IA, IN, KS, MI, MO, NE

coverage indications, limitations, and/or medical necessity

osteoporotic conditions

Painful, debilitating, osteoporotic vertebral collapse/compression fractures, that have not responded to non-surgical management (e.g. narcotic and/or non-narcotic medication, physical therapy modalities) with or without methods of immobility (e.g. bed rest, bracing). Both Percutaneous Vertebroplasty (PVP) and Percutaneous Vertebral Augmentation (PVA) will be considered reasonable and necessary for osteoporotic conditions when all of the following criteria are met:

all of the following

- acute (<6 weeks) or subacute (6-12 weeks) osteoporotic VCF (T1 – L5) based on symptom onset
- recent (within 30 days) advanced imaging (bone marrow edema on MRI or bone-scan/ SPECT/CT uptake)
- all patients presenting with VCF should be referred for evaluation of bone mineral density and osteoporosis education for subsequent treatment as indicated and instructed to take part in an osteoporosis prevention/treatment program

malignant vertebral fractures

Osteolytic vertebral metastasis or myeloma with severe back pain related to a destruction of the vertebral body, not involving the major part of the cortical bone.

one of the following

- painful osteolytic metastasis
- multiple myeloma with painful vertebral body involvement

+ one of the following

- symptomatic and is hospitalized with severe pain (NRS or VAS pain score ≥ 8) or
- non-hospitalized with moderate to severe pain (NRS or VAS ≥ 5) despite optimal non-surgical management (NSM) + worsening pain or
- non-hospitalized with moderate to severe pain (NRS or VAS ≥ 5) despite optimal non-surgical management (NSM) + stable to improved pain (but NRS or VAS ≥ 5) when 2 or more of the following are present:
 - progression of vertebral body height loss
 - $> 25\%$ vertebral body height reduction
 - kyphotic deformity
 - severe impact of VCF on daily functioning (Roland Morris Disability Questionnaire (RDQ) > 17)
 - steroid induced-fractures
 - reinforcement or stabilization of vertebral body prior to surgery

traumatic compression fractures

Please note: Medtronic PVP and PKP systems are not indicated for traumatic compression fracture. This section is included to summarize the full LCD, which includes traumatic VCF.

WPS is reinstating coverage for PVA as reasonable and necessary for the following traumatic conditions:

one of the following

- stable and/or unstable burst fractures
- wedge compression fractures
- fracture- dislocations that occur following auto accidents or falls from height

limitations

absolute contraindication

- current back pain is not primarily due to the identified acute VCF(s)
- osteomyelitis, discitis, or active systemic infection

relative contraindication

<input type="radio"/> greater than three vertebral fractures per procedure	<input type="radio"/> neurologic deficit
<input type="radio"/> allergy to bone cement or opacification agents	<input type="radio"/> neural impingement
<input type="radio"/> uncorrected coagulopathy	<input type="radio"/> fracture retropulsion / canal compromise
<input type="radio"/> spinal instability	<input type="radio"/> pregnancy
<input type="radio"/> myelopathy from the fracture	

CPT codes for percutaneous vertebral augmentation

22510, 22511, 22512, 22513, 22514, 22515

ICD-10 diagnosis codes that support medical necessity

As specified in [WPS Local Coverage Article \(LCA\) A57630](#). Access LCA for code descriptions.

group 1 codes (osteoporotic vertebral fractures)

M80.08XA M80.08XS M80.88XA M80.88XS

group 2 codes (malignant fractures)

C41.2*	C90.01*	C96.6	D47.1	E24.2	E24.8	T38.0X5A
C79.51*	C90.02*	C96.A	E24.0	E24.3	E24.9	T38.0X5D
C79.52*	C96.5	D16.6	E24.1	E24.4	M81.6	T38.0X5S
C90.00*						

* A dual diagnosis is required. Requires one of the above group 2 codes and one ICD-10 diagnosis code from group 3 codes below.

group 3 codes

one of the following ICD-10 diagnosis codes is required as a dual diagnosis with a group 2 code. See Group 2 Medical Necessity ICD-10 codes asterisk.

M84.58XA M84.58XD M84.58XG M84.58XK M84.58XP M84.58XS

group 4 codes (traumatic vertebral fractures)

Please note: For codes in the table below that may require a 7th character, letters A, D, G, K, and S may be used as appropriate for the code.

M48.33	S22.012A	S22.038A	S22.060A	S22.081A	S32.022A	S32.048A
M48.34	S22.018A	S22.040A	S22.061A	S22.082A	S32.028A	S32.050A
M48.35	S22.020A	S22.041A	S22.062A	S22.088A	S32.030A	S32.051A
M48.36	S22.021A	S22.042A	S22.068A	S32.010A	S32.031A	S32.052A
M48.37	S22.022A	S22.048A	S22.070A	S32.011A	S32.032A	S32.058A
S12.690A	S22.028A	S22.050A	S22.071A	S32.012A	S32.038A	
S12.691A	S22.030A	S22.051A	S22.072A	S32.018A	S32.040A	
S22.010A	S22.031A	S22.052A	S22.078A	S32.020A	S32.041A	
S22.011A	S22.032A	S22.058A	S22.080A	S32.021A	S32.042A	

Disclaimer: Please note these group 4 codes are only included on the LCD/LCA check-off sheet so that an accurate representation of the full and complete WPS LCD/LCA conditions and requirements for PVA are reflected. However, these codes are considered off label for Medtronic and should be not perceived that MDT is promoting the use of these codes. They are included only to serve for educational LCD/LCA purposes only.



Questions

[Email: neuro.us.reimbursement@medtronic.com](mailto:neuro.us.reimbursement@medtronic.com)

Resources

[WPS Local Coverage Determination \(LCD\) L38213](#)
[WPS Local Coverage Article \(LCA\) A57630](#)