Henry Mayo Newhall Hospital

INDICATIONS FOR
Vertebral Augmentation for Osteoporotic Vertebral Compression Fracture (VCF)

Patient:____ DOB_______________

Inclusion Criteria (ALL ARE REQUIRED)

Please indicate which of these diagnoses you are performing the surgery for:

Diagnosis Codes:

1.

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

2. **Sympton Onset**

❏ Acute (< 6 weeks) Date of symptom onset: _______________

❏ Subacute (6-12 weeks) Date of symptom onset: _______________

3. **Documentation must be attached**

❏ MRI Date of study: _____________

OR

❏ Bone-scan/SPECT/CT uptake Date of study: _______________

Documentation attached: ❏ Yes

4. ❏ Hospitalized with severe pain (NRS) or (VAS) pain score = 8)

Pain Scale Rating: _____________

~OR~

❏ Non-hospitalized with moderate to severe pain NRS or VAS pain score = 5 despite optimal non-surgical management (NSM) (ONE):

- ❏ Worsening pain
- ❏ Stable to improved pain but NRS or VAS still =5
  And more than 2 of the following:
  - ❏ Progression of vertebral body height loss
  - ❏ > 25% vertebral body height reduction
  - ❏ Kyphotic deformity
  - ❏ Severe impact of VCF on daily functioning

5. Referred for

❏ evaluation of bone mineral density (BMD) and osteoporosis education for subsequent treatment as indicated

6. ❏ Instructed to take part in an osteoporosis prevention/treatment program

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Patient:____ DOB_______________

Does the patient have any of the following exclusion criteria? (check all that apply to the patient)

(Can have NONE of the following)

❑	None of the exclusion criteria below apply to this patient
❑	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
❑	Greater than three vertebral fractures per procedures
❑	Allergy to bone cement or opacification agents
❑	Uncorrected coagulopathy
❑	Spinal instability
❑	Myelopathy from the fracture
❑	Neurological deficit
❑	Neural impairment
❑	Facture retropulsion/canal compromise

The patient and the treating physicians have concluded that the patient has exhausted all conservative measures at this time and now will benefit from Spinal Surgery. This treatment is necessary for the patient to return to a functional and pain manageable condition.

It is the responsibility of the ordering, referring physician to establish medical necessity and must have documentation in their medical records to support these coverage indications, limitations, and/or medical necessity.

Procedure: ❑ Percutaneous Vertebroplasty (PVP) ❑ Percutaneous Kyphoplasty (PKP)

Physician Signature: ______________________________ Date: ____________ Time: ____________