Part B Insider (Multispecialty) Coding Alert

PHYSICIANS: CMS Issues Technology Assessment For Kyphoplasty, Vertebroplasty

Results could erase current carrier coverage policies

The **Centers for Medicare and Medicaid Services** has moved one step closer to a national coverage determination for percutaneous vertebroplasty and percutaneous kyphoplasty for vertebral fractures caused by osteoporosis and malignancy.

Unfortunately, the technology assessment seems inconclusive. The researchers decided "the available evidence does not permit conclusions regarding the effect" of the two procedures on health outcomes. They also said it hasn't yet been demonstrated whether they improve health outcomes "in the investigational setting. Therefore, it cannot be demonstrated whether improvement is attainable outside the investigational settings."

CMS will host a meeting of the **Medicare Coverage Advisory Committee** on May 24 to discuss these assessments.

The stakes are high for this process, because if CMS issues a national coverage determination stating that Medicare won't cover vertebroplasty or kyphoplasty for osteoporsis- or malignancy- related vertebral fractures, then it'll override the carrier policies. Currently, several carriers have fairly liberal policies on both procedures, says **Heidi Stout**, coding and reimbursement specialist with **University Orthopedic Associates** in New Brunswick, NJ.

The vast majority of both procedures are done for "pathologic fractures in people with osteoporosis," Stout adds. But she points out that it's too early to tell what the final impact of the coverage process will be because the technology assessment only said there isn't enough information to make a decision one way or the other.

In other news:

1. Cambridge, MA physician **Vladimir Shurlan** pleaded guilty to engaging in a health care fraud scheme, according to a May 16 **Department of Justice** press release. From August 2000 to January 2003, Shurlan allegedly received more than $24,000 in excess Medicare reimbursement, the DOJ says.

   Shurlan admitted he submitted fraudulent billings to Medicare for services he never provided and misrepresented services billed to private insurance companies. He continued to bill fraudulently even after a private insurance company sent him a letter calling his claims a "gross misrepresentation of the services performed," the DOJ says.

   Shurlan agreed to repay Medicare $89,153 and various private payers $56,425 and could face six to 12 months in prison.

2. CMS revised payment levels for a number of drugs, for both the first and second quarter 2005 payment levels, including hepatitis B vaccine (90747), Adalimumab injection (J0135), Cytara- bine liposome (J9098) and Pegaspargase (**J9266**). The change took place in Transmittal 561, issued May 13.