Percutaneous Sacroplasty

**Description:**

Percutaneous sacroplasty has been investigated as a technique to provide stabilization to the sacral area. Using a computerized tomography (CT) or fluoroscopic guidance, polymethylmethacrylate cement is injected into the sacral fracture(s).

The safety and efficacy of sacroplasty has not yet been proven. Evidence to date is limited to individual case reports, small case series with limited followup, and no randomized controlled trials have been completed. At this time percutaneous sacroplasty is not medically necessary as there is insufficient peer-reviewed scientific literature that demonstrates that the procedure/service is effective.

**Medical Criteria:**

Not applicable.

**Policy:**

Percutaneous sacroplasty is considered **not medically necessary** as there is insufficient peer-reviewed medical literature to support the efficacy of this treatment.

**Coverage:**

Benefits may vary between groups/contracts. Please refer to the Evidence of Coverage, Subscriber Agreement, Benefit Booklet, or Rite Care Contract for **not medically necessary** services.

**Coding:**

The following Category III CPT codes are considered not medically necessary:

- 0200T
- 0201T

The imaging guidance procedure that is to be used with these codes is:

- 72291

**Also known as:**

Not applicable

**Related topics:**

Not applicable

**Published:**

*Provider Update*, July 2009

**Bibliography**


This medical policy is made available to you for informational purposes only. It is not a guarantee of payment or a substitute for your medical judgement in the treatment of your patients. Benefits and eligibility are determined by the member's subscriber agreement or member certificate and/or the employer agreement, and those documents will supersede the provisions of this medical policy. For information on member-specific benefits, call the provider call center. If you provide services to a member which are determined to not be medically necessary (or in some cases medically necessary services which are non-covered benefits), you may not charge the member for the services unless you have informed the member and they have agreed in writing in advance to continue with the treatment at their own expense. Please refer to your participation agreement(s) for the applicable provisions.

This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. BCBSRI reserves the right to review and revise this policy for any reason and at any time, with or without notice.

🔗 Back to Previous Page