

# Medicare Vertebral Augmentation Procedure (VAP) Documentation Worksheet

Medical record documentation should also include a comprehensive pain assessment/management plan and a detailed operative report. Refer also to Medicare Vertebral Augmentation Documentation Guidelines for additional details pertinent to each section of the Worksheet.

**Patient Name:** \_\_\_\_\_

**Procedure:** \_\_\_\_\_

**I. Indication/Diagnosis including vertebrae affected and any underlying etiology (for Multiple Myeloma and Hemangioma refer to VAP Documentation Guidelines):**

\_\_\_\_\_

**II. Describe the severity of the patient's pain, functional limitations, and impact on ADLs:**

\_\_\_\_\_

\_\_\_\_\_

**III. Describe any previous surgical treatments and outcomes:**

\_\_\_\_\_

\_\_\_\_\_

**IV. Provide assessment regarding whether the patient is neurologically intact relative to the levels of proposed treatment:**

\_\_\_\_\_

\_\_\_\_\_

**V. Describe previous conservative medical management that has been tried and failed or why conservative medical management is not appropriate for the patient:**

A. Pre-operative supervised physical therapy with frequency and duration:

\_\_\_\_\_

\_\_\_\_\_

B. Bed rest/activity modification/restriction and duration:

\_\_\_\_\_

\_\_\_\_\_

C. Bracing/immobilization and duration:

\_\_\_\_\_

\_\_\_\_\_

D. Local or systemic analgesics (e.g. narcotic or non-narcotic drugs) and duration of treatment:

\_\_\_\_\_

\_\_\_\_\_

E. In the absence of conservative medical management, describe why such management is not appropriate:

\_\_\_\_\_

\_\_\_\_\_

F. Describe any additional rationale for proceeding with VAP:

\_\_\_\_\_

\_\_\_\_\_

**VI. Describe your findings related to x-ray and/or MRI (e.g. duration/anatomy of fracture, posterior vertebral body wall deficiency):**

\_\_\_\_\_

\_\_\_\_\_

**Physician Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Physician Name** \_\_\_\_\_ **Time** \_\_\_\_\_

