CLINICAL GUIDELINES

Spine Surgery

Version V1.0
Effective February 14, 2020

Clinical guidelines for medical necessity review of spine surgery services.

Spine Surgery Guidelines

400 Buckwalter Place Boulevard, Bluffton, SC 29910 (800) 918-8924

CMM-600: Preface to Spine Surgery Guidelines

CMM-600.1: Prior Authorization Requirements

- Prior-authorization requests should be submitted at least two weeks prior to the anticipated date of an elective spinal surgery.
- Minimum documentation requirements needed to complete a prior authorization request for spinal surgery include **ALL** of the following:
  - CPT codes, disc level(s) or motion segments involved for planned surgery, and ICD-10 codes
  - Detailed documentation of the type, duration, and frequency of provider-directed non-surgical treatment (e.g. interventional pain management, medication management, physical therapy, chiropractic care, provider-directed active exercise program, etc.) and the response to each treatment
    - Detailed documentation explaining why a sufficient trial of non-surgical treatment was contraindicated if applicable
    - Detailed documentation of less than clinically meaningful improvement for each treatment.
  - Written reports/interpretations of the most recent advanced diagnostic imaging studies (e.g. CT, MRI, Myelography) by an independent radiologist. Clinically significant discrepancies in interpretations between the surgeon and the radiologist need to be reconciled in the documentation submitted for prior authorization.
    - Acceptable imaging modalities for purposes of the Spine Surgery guidelines are: CT, MRI, and Myelography.
    - Discography results will not be used as a determining factor of medical necessity for any requested procedure. Discography use is not endorsed.
  - For spinal fusion surgery requests: documentation of flexion-extension plain X-rays based upon indications for instability and/or other plain X-rays that document failure of instrumentation, fusion, etc.
  - Documentation of nicotine-free status as evidenced by **EITHER** of the following, unless this is an urgent/emergent request, for decompression only without fusion, disc arthroplasty, or when myelopathy is present:
    - Patient is a never-smoker
    - Patient has refrained from smoking, use of smokeless tobacco products, and/or nicotine replacement therapy for at least 6 weeks prior to planned surgery as evidenced by blood cotinine lab results of ≤ 10 ng/mL
      - **Note:** In order to complete the prior authorization process for spinal fusion surgery, allow for sufficient time for submission of lab results performed after the 6-week cessation period.
  - Some procedures in the eviCore Spine Surgery Guidelines require a trial of epidural steroid injection(s) (ESIs)/selective nerve root blocks (SNRBs) unless there is a documented contraindication(s) to ESIs/SNRBs.;Contraindications to ESIs/SNRBs include the presence of **ANY** of the following:
    - Allergy to the medication to be administered
    - A significantly altered or eliminated epidural space (e.g. congenital anatomic anomalies or previous surgery)
    - Anticoagulation therapy

- Bleeding disorder
- Localized infection in the region to be injected
- Systemic infection
- Other co-morbidities which could be exacerbated by steroid usage (e.g. poorly controlled hypertension, severe congestive heart failure, diabetes, etc.)

CMM-600.2: Urgent/Emergent Requests

- All patients being evaluated for spine surgery should be screened for indications of a medical condition that requires urgent/emergent treatment. The presence of such indications/conditions warrants definitive surgical treatment in lieu of provider-directed non-surgical management and/or proof of smoking cessation. Confirmatory imaging studies are required.
- An urgent/emergent request is based on the 2019 NCQA standards for utilization management and is as follows:
  - A request for medical care or services where application of the time frame for making routine or non-life threatening care determinations:
    - Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or
    - Could seriously jeopardize the life, health, or safety of the member or others, due to the member's psychological state, or
    - In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

CMM-600.3: References

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CMM-601: Anterior Cervical Discectomy and Fusion

CMM-601.1: General Guidelines

- The determination of medical necessity for the performance of cervical fusion with and without discectomy is always made on a case-by-case basis.
- For prior authorization requirements, see **CMM-600.1: Prior Authorization Requirements**.
- The presence of urgent/emergent indications/conditions warrants definitive surgical treatment. Confirmatory advanced imaging studies are required. The following criteria are **NOT** required for confirmed urgent/emergent conditions:
  - Provider-directed non-surgical management
  - Proof of smoking cessation
  - Recent (within 6 months) plain X-rays of the cervical spine
  - Absence of unmanaged significant behavioral health disorders
- Urgent/emergent conditions for cervical fusion with and without discectomy include **ANY** of the following:
  - Acute/unstable traumatic spinal fractures or dislocations with or without neural compression
  - Central cord syndrome
  - Documentation of progressive neurological deficit on two separate physical examinations
  - Severe or rapidly progressive symptoms of motor loss, bowel incontinence or bladder incontinence/retention due to a neurocompressive pathology
  - Epidural hematoma
  - Infection (e.g. discitis, epidural abscess, osteomyelitis)
  - Myelopathy
  - Occipitocervical and/or Atlantoaxial (C1-C2) instability (non-traumatic) due to **ANY** of the following:
    - Rheumatoid arthritis
    - Congenital abnormality of occipitocervical/C1-C2 vertebrae
    - Os odontoideum
  - Neoplasms of the spine
  - Primary or metastatic neoplastic disease causing pathologic fracture, cord compression or instability
  - Documentation of severe debilitating pain and/or dysfunction to the point of being incapacitated
  - Flexion-extension plain X-rays demonstrate instability and include **ANY** of the following:
    - >3.5 mm sagittal plane translation
    - >20% sagittal plane translation of vertebral body width
    - >11 degrees relative sagittal plane angulation

CMM-601.2: Initial Primary Anterior Cervical Discectomy and Fusion (ACDF)

Initial primary anterior cervical discectomy and fusion (ACDF) is considered medically necessary when ALL of the following are met:

- Recent (within 6 months) plain X-rays of the cervical spine have been performed
- No previous surgeries on the disc(s) involved with the exception of posterior laminoforaminotomies or laminoplasty in a patient with myelopathy from ventral neurocompression
- Absence of unmanaged significant behavioral health disorders (e.g. major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse)
- Performed for **EITHER** of the following conditions:
  - Radiculopathy when **ALL** of the following are met:
    - Subjective symptoms including **BOTH** of the following:
      - Significant level of pain on a daily basis defined as **EITHER** of the following:
        - Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
        - Severe, disabling, crippling, or incapacitating pain
      - Unremitting radicular pain to shoulder girdle and/or upper extremity with or without concordant objective physical examination findings resulting in disability
    - Objective physical examination findings including **ANY** of the following:
      - Dermatomal sensory deficit
      - Motor deficit (e.g. biceps, triceps weakness)
      - Reflex changes
      - Shoulder Abduction Relief Sign
      - Nerve root tension sign (e.g. Spurling's maneuver)
      - Unremitting radicular pain to shoulder girdle and/or upper extremity without concordant objective physical examination findings
    - Less than clinically meaningful improvement with at least **TWO** of the following unless contraindicated:
      - Prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks
      - Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks
      - Epidural steroid injection(s)/selective nerve root block(s)
    - Recent (within 6 months) MRI/CT identifies nerve root impingement caused by herniated disc(s) and/or osteophytes that is concordant with the patient's symptoms and physical examination findings
    - Documentation of nicotine-free status with **EITHER** of the following:
      - Patient is a never-smoker
      - Patient has refrained from smoking, use of smokeless tobacco products, and/or nicotine replacement therapy for at least 6 weeks prior to planned surgery as evidenced by blood cotinine lab results of ≤ 10 ng/mL

- Myelopathy when **ALL** of the following are met:
  - Subjective symptoms including **ANY** of the following:
    - Upper/lower extremity weakness, numbness, or pain
    - Fine motor dysfunction (buttoning, handwriting, clumsiness of hands)
    - New-onset bowel or bladder dysfunction due to a neurocompressive pathology
    - Frequent falls
  - Objective physical examination findings including at least **TWO** of the following:
    - Grip and release test
    - Ataxic gait
    - Hyperreflexia
    - Hoffmann sign
    - Pathologic Babinski sign
    - Tandem walking test
    - Inverted brachial radial reflex
    - Increased muscle tone or spasticity
    - Clonus
    - Myelopathic hand
  - Recent (within 6 months) MRI/CT findings that are concordant with the patient's symptoms and physical examination findings including **EITHER** of the following:
    - MRI/CT demonstrates cervical spinal cord compression
    - MRI/CT identifies cervical spinal stenosis

CMM-601.3: Repeat Anterior Cervical Discectomy and Fusion (ACDF) at the Same Level

Requests for cervical fusion with a history of two (2) or more cervical fusions requires medical review.

Repeat anterior cervical discectomy and fusion (ACDF) at the same level is considered medically necessary for ANY of the following:

- Painful pseudarthrosis documented by confirmatory imaging that is unresponsive to 6 months of non-surgical treatment
- Recent (within 6 months) post-operative plain X-rays of the cervical spine including flexion/extension lateral views with radiographic evidence of implant/structural bone graft malposition or implant/structural bone graft failure
- Performed for **ANY** of the following conditions:
  - Unremitting neck pain when **ALL** of the following are met:
    - Significant level of pain on a daily basis defined as **EITHER** of the following:
      - Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
      - Severe, disabling, crippling, or incapacitating pain
    - Greater than 6 months since prior anterior cervical discectomy and fusion (ACDF) procedure at the same level

- Absence of unmanaged significant behavioral health disorders (e.g. major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse)
- Less than clinically meaningful improvement with **BOTH** of the following unless contraindicated:
  - Prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks
  - Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks
- Recent (within 6 months) post-operative MRI/CT findings that are concordant with the patient's symptoms and/or physical examination findings presenting post-operatively
- Documentation of nicotine-free status including **EITHER** of the following:
  - Patient is a never-smoker
  - Patient has refrained from smoking, use of smokeless tobacco products, and/or nicotine replacement therapy for at least 6 weeks prior to planned surgery as evidenced by blood cotinine lab results of ≤ 10 ng/mL

◆ Radiculopathy secondary to herniated disc or osteophyte when **ALL** of the following are met:

- Initial relief of symptoms following previous disc decompression procedure at the same level
- Absence of unmanaged significant behavioral health disorders (e.g. major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse)
- Greater than 6 weeks since the initial anterior cervical discectomy/fusion surgery
- Subjective symptoms including **BOTH** of the following:
  - Significant level of pain on a daily basis defined as **EITHER** of the following:
    - Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
    - Severe, disabling, crippling, or incapacitating pain
  - Unremitting radicular pain to shoulder girdle and/or upper extremity resulting in disability
- Objective physical examination findings including **ANY** of the following:
  - Dermatomal sensory deficit
  - Motor deficit (e.g. biceps, triceps weakness)
  - Reflex changes
  - Shoulder Abduction Relief Sign
  - Nerve root tension sign (e.g. Spurling's maneuver)
  - Unremitting radicular pain to shoulder girdle and/or upper extremity without concordant objective physical examination findings
- Less than clinically meaningful improvement with at least **TWO** of the following unless contraindicated:
  - Prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks
  - Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks

        - Selective nerve root block(s) performed at the same level(s) as the requested ACDF or epidural steroid injection(s)
    - Recent (within 6 months) post-operative confirmatory imaging including **EITHER** of the following that is concordant with the patient's symptoms and physical examination findings:
        - MRI /CT confirms evidence of neural structure compression (e.g. either retained disc material or a recurrent disc herniation)
        - CT documenting pseudarthrosis, no less than 6 months after initial fusion
    - Documentation of nicotine-free status including **EITHER** of the following:
        - Patient is a never-smoker
        - Patient has refrained from smoking, use of smokeless tobacco products, and/or nicotine replacement therapy for at least 6 weeks prior to planned surgery as evidenced by blood cotinine lab results of ≤ 10 ng/mL
- Myelopathy when **ALL** of the following are met:
    - Initial relief of symptoms following previous disc decompression procedure at the same level
    - Absence of unmanaged significant behavioral health disorders (e.g. major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse)
    - Subjective symptoms including **ANY** of the following:
        - Upper/lower extremity weakness, numbness, or pain
        - Fine motor dysfunction (buttoning, handwriting, clumsiness of hands)
        - New-onset bowel or bladder dysfunction due to a neurocompressive pathology
        - Frequent falls
    - Objective physical examination findings including at least **TWO** of the following:
        - Grip and release test
        - Ataxic gait
        - Hyperreflexia
        - Hoffmann sign
        - Pathologic Babinski sign
        - Tandem walking test
        - Inverted brachial radial reflex
        - Increased muscle tone or spasticity
        - Clonus
        - Myelopathic hand
    - Recent (within 6 months) post-operative confirmatory MRI/CT findings including **ANY** of the following:
        - MRI /CT confirms evidence of neural structure compression
        - MRI /CT identifies stenosis
        - CT scan documenting pseudarthrosis, no less than 6 months after initial fusion

CMM-601.4: Adjacent Segment Disease

Anterior cervical discectomy and fusion (ACDF) for a degenerative spinal segment adjacent to a previous decompression or fusion procedure is considered **medically necessary** when **ALL** of the following are met:

- Recent (within 6 months) plain X-rays of the cervical spine including flexion/extension lateral views and advanced diagnostic imaging demonstrating successful decompression and/or fusion at the adjacent level
- The prior decompression or fusion procedure at an adjacent level was performed at least 6 months prior.
- No previous surgeries on the disc(s) involved
- Absence of unmanaged significant behavioral health disorders (e.g. major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse)
- Performed for **EITHER** of the following conditions:
  - Radiculopathy when **ALL** of the following are met:
    - Subjective symptoms including **BOTH** of the following:
      - Significant level of pain on a daily basis defined as **EITHER** of the following:
        - Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
        - Severe, disabling, crippling, or incapacitating pain
      - Unremitting radicular pain to shoulder girdle and/or upper extremity resulting in disability
    - Objective physical examination findings including **ANY** of the following:
      - Dermatomal sensory deficit
      - Motor deficit (e.g. biceps, triceps weakness)
      - Reflex changes
      - Shoulder Abduction Relief Sign
      - Nerve root tension sign (e.g. Spurling's maneuver)
      - Unremitting radicular pain to shoulder girdle and/or upper extremity without concordant objective physical examination findings
    - Less than clinically meaningful improvement with at least **TWO** of the following unless contraindicated:
      - Prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks
      - Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks
      - Epidural steroid injection(s)/selective nerve root block(s)
    - Recent (within 6 months) MRI/CT identifies nerve root impingement caused by herniated disc(s) or osteophytes that is concordant with the patient's symptoms and physical examination findings
    - Documentation of nicotine-free status with **EITHER** of the following:
      - Patient is a never-smoker
      - Patient has refrained from smoking, use of smokeless tobacco products, and/or nicotine replacement therapy for at least 6 weeks prior to planned surgery as evidenced by blood cotinine lab results of ≤ 10 ng/mL

- Myelopathy when **ALL** of the following are met:
  - Subjective symptoms including **ANY** of the following:
    - Upper/lower extremity weakness, numbness, or pain
    - Fine motor dysfunction (buttoning, handwriting, clumsiness of hands)
    - New-onset bowel or bladder dysfunction due to a neurocompressive pathology
    - Frequent falls
  - Objective physical examination findings including at least **TWO** of the following:
    - Grip and release test
    - Ataxic gait
    - Hyperreflexia
    - Hoffmann sign
    - Pathologic Babinski sign
    - Tandem walking test
    - Inverted brachial radial reflex
    - Increased muscle tone or spasticity
    - Clonus
    - Myelopathic hand
  - Recent (within 6 months) MRI/CT findings that is concordant with the patient's symptoms or physical examination findings including **EITHER** of the following:
    - MRI/CT demonstrates cervical spinal cord compression
    - MRI/CT identifies cervical spinal stenosis

CMM-601.5: Failed Cervical Disc Arthroplasty Implant

Anterior cervical decompression and fusion following failed cervical disc arthroplasty implant is considered **medically necessary** for **EITHER** of the following:

- Recent (within 6 months) post-operative imaging studies demonstrating failure of a cervical disc arthroplasty implant (i.e. subsidence, loosening, infection, dislocation, subluxation, vertebral body fracture, dislodgement)
- Performed for **ANY** of the following conditions:
  - Unremitting neck pain when **ALL** of the following are met:
    - Significant level of pain on a daily basis defined as **EITHER** of the following:
      - Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
      - Severe, disabling, crippling, or incapacitating pain
    - Greater than 6 months since prior since prior cervical disc arthroplasty procedure at the same level
    - Absence of unmanaged significant behavioral health disorders (e.g. major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse)
    - Less than clinically meaningful improvement with prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks unless contraindicated
    - Recent (within 6 months) post-operative MRI/CT findings that are concordant with the patient's symptoms or physical examination findings
    - Documentation of nicotine-free status including **EITHER** of the following:
      - Patient is a never-smoker

        - Patient has refrained from smoking, use of smokeless tobacco products, and/or nicotine replacement therapy for at least 6 weeks prior to planned surgery as evidenced by blood cotinine lab results of ≤ 10 ng/mL
- Radiculopathy when **ALL** of the following are met:
    - Greater than 6 months since the prior cervical disc arthroplasty procedure
    - Absence of unmanaged significant behavioral health disorders (e.g. major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse)
    - Subjective symptoms including **BOTH** of the following:
        - Significant level of pain on a daily basis defined as **EITHER** of the following:
            - Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
            - Severe, disabling, crippling, or incapacitating pain
        - Unremitting radicular pain to shoulder girdle and/or upper extremity resulting in disability
    - Objective physical examination findings including **ANY** of the following:
        - Dermatomal sensory deficit
        - Motor deficit (e.g. biceps, triceps weakness)
        - Reflex changes
        - Shoulder Abduction Relief Sign
        - Nerve root tension sign (e.g. Spurling's maneuver)
        - Unremitting radicular pain to shoulder girdle and/or upper extremity without concordant objective physical examination findings
    - Less than clinically meaningful improvement with any **TWO** of the following unless contraindicated:
        - Prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks
        - Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks
        - Epidural steroid injection(s)/selective nerve root block(s)
    - Recent (within 6 months) post-operative MRI/CT identifies nerve root impingement caused by herniated disc(s) or osteophytes that is concordant with the patient's symptoms or physical examination findings
    - Documentation of nicotine-free status including **EITHER** of the following:
        - Patient is a never-smoker
        - Patient has refrained from smoking, use of smokeless tobacco products, and/or nicotine replacement therapy for at least 6 weeks prior to planned surgery as evidenced by blood cotinine lab results of ≤ 10 ng/mL
- Myelopathy when **ALL** of the following are met:
    - Greater than 6 months since the prior cervical disc arthroplasty procedure
    - Absence of unmanaged significant behavioral health disorders (e.g. major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse)
    - Subjective symptoms including **ANY** of the following:
        - Upper/lower extremity weakness, numbness, or pain
        - Fine motor dysfunction (buttoning, handwriting, clumsiness of hands)

- New-onset bowel or bladder dysfunction due to a neurocompressive pathology
- Frequent falls

- Objective physical examination findings including at least **TWO** of the following:
  - Grip and release test
  - Ataxic gait
  - Hyperreflexia
  - Hoffmann sign
  - Pathologic Babinski sign
  - Tandem walking test
  - Inverted brachial radial reflex
  - Increased muscle tone or spasticity
  - Clonus
  - Myelopathic hand
- Recent (within 6 months) post-operative MRI/CT findings that are concordant with the patient's symptoms or physical examination findings including **ANY** of the following:
  - MRI/CT demonstrates cervical spinal cord compression
  - MRI/CT identifies cervical spinal stenosis

CMM-601.6: Non-Indications

- Anterior cervical discectomy and fusion (ACDF) is **not medically necessary** for **EITHER** of the following:
  - Chronic non-specific neck or arm pain of unknown etiology
  - Cervical degenerative disc disease without radiculopathy or myelopathy

CMM-601.7: Procedure (CPT®) Codes

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code's inclusion on this list does not necessarily indicate prior authorization is required.	
CPT®	**Code Description/Definition**
22548	Arthrodesis, anterior transoral or extraoral technique, clivus-C1-C2 (atlas-axis), with or without excision of odontoid process
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2
+22552	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for separate procedure)
22554	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2
+22585	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)
+22840	Posterior non-segmental instrumentation (e.g. Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)
+22845	Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)
+22846	Anterior instrumentation; 4 to 7 vertebral segments (List separately in addition to code for primary procedure)
+22853	Insertion of interbody biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (List separately in addition to code for primary procedure)
+22854	Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)
+22859	Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)
63075	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace
+63076	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace (List separately in addition to code for primary procedure)
63081	Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve roots(s); cervical, single segment
+63082	Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve roots(s); cervical, single segment; cervical, each additional segment (List separately in addition to code for primary procedure)
This list may not be all inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the health plan and is based on the individual's policy or benefit entitlement structure as well as claims processing rules.	

CMM-601.8: References

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CMM-602: Cervical Total Disc Arthroplasty

CMM-602.1: General Guidelines

- The determination of medical necessity for the performance of cervical total disc arthroplasty is always made on a case-by-case basis.
- For prior authorization requirements, see **CMM-600.1: Prior Authorization Requirements**.
- The presence of urgent/emergent indications/conditions warrants definitive surgical treatment. Confirmatory advanced imaging studies are required. The following criteria are **NOT** required for confirmed urgent/emergent conditions:
  - Provider-directed non-surgical management
  - Absence of unmanaged significant behavioral health disorders
- Urgent/emergent conditions for cervical total disc arthroplasty include **ANY** of the following:
  - Myelopathy
  - Central cord syndrome
  - Documentation of progressive neurological deficit on two separate physical examinations
  - Severe or rapidly progressive symptoms of motor loss, bowel incontinence or bladder incontinence/retention due to a neurocompressive pathology
  - Documentation of severe debilitating pain and/or dysfunction to the point of being incapacitated

CMM-602.2: Initial Primary Cervical Total Disc Arthroplasty

Initial primary cervical total disc arthroplasty is considered medically necessary when ALL of the following are met:

- The patient has degenerative cervical disc disease with intractable radiculopathy and/or myelopathy, producing symptomatic nerve root and/or spinal cord compression due to herniated disc and/or osteophyte formation.
- The patient is skeletally mature.
- An FDA approved implant is used in accordance with FDA labeling:
  - **ANY** of the following for single level cervical disc arthroplasty:
    - PRESTIGE ST™ / PRESTIGE LP® / PRESTIGE® Cervical Disc
    - ProDisc®-C
    - BRYAN® Cervical Disc
    - SECURE-C® Cervical Artificial Disc
    - Mobi-C®
    - PCM Cervical Disc
    - M6-C™ Artificial Cervical Disc
  - **EITHER** of the following for two level cervical disc arthroplasty:
    - Mobi-C®
    - PRESTIGE LP®
- No previous surgeries on the disc(s) involved

- The planned implant(s) will be used in the reconstruction of cervical disc(s) at C3-C7, following discectomy.
- The patient is a candidate for single-level or two level anterior cervical decompression(s) and interbody fusion(s)
- Absence of unmanaged significant behavioral health disorders (e.g. major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse)
- Absence of clinically significant cervical instability on neutral resting or lateral flexion/extension plain X-rays, defined as kyphotic deformity/significant reversal or lordosis or spondylolisthesis (e.g. > 3.5 mm subluxation/translation or > 11 degrees angulation/rotational difference) from that of either adjacent spinal level
- Performed for **EITHER** of the following conditions:
  - Radiculopathy when **ALL** of the following are met:
    - Subjective symptoms including **BOTH** of the following:
      - Significant level of pain on a daily basis defined as **EITHER** of the following:
        - Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
        - Severe, disabling, crippling, or incapacitating pain
      - Unremitting radicular pain to shoulder girdle and/or upper extremity resulting in disability
    - Objective physical examination findings including **ANY** of the following:
      - Dermatomal sensory deficit
      - Motor deficit (e.g. biceps, triceps weakness)
      - Reflex changes
      - Shoulder Abduction Relief Sign
      - Nerve root tension sign (e.g. Spurling's maneuver)
      - Unremitting radicular pain to shoulder girdle and/or upper extremity without concordant objective physical examination findings
    - Less than clinically meaningful improvement with at least **TWO** of the following unless contraindicated:
      - Prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks
      - Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks
      - Epidural steroid injection(s)/selective nerve root block(s)
    - Recent (within 6 months) MRI/CT identifies nerve root impingement caused by herniated disc(s) and/or osteophytes that is concordant with the patient's symptoms and physical examination findings
  - Myelopathy when **ALL** of the following are met:
    - Subjective symptoms including **ANY** of the following:
      - Upper/lower extremity weakness, numbness, or pain
      - Fine motor dysfunction (buttoning, handwriting, clumsiness of hands)
      - Urinary urgency
      - New-onset bowel or bladder dysfunction due to a neurocompressive pathology
      - Frequent falls

- Objective physical examination findings including at least **TWO** of the following:
  - Grip and release test
  - Ataxic gait
  - Hyperreflexia
  - Hoffmann sign
  - Pathologic Babinski sign
  - Tandem walking test
  - Inverted brachial radial reflex
  - Increased muscle tone or spasticity
  - Clonus
  - Myelopathic hand
- Recent (within 6 months) MRI/CT findings that are concordant with the patient's symptoms and physical examination findings including **EITHER** of the following:
  - MRI/CT demonstrates cervical spinal cord compression
  - MRI/CT identifies cervical spinal stenosis

CMM-602.3: Failed Cervical Total Disc Arthroplasty Implant

Revision of a failed cervical total disc arthroplasty is considered medically necessary when the patient is a candidate for single-level or two level anterior cervical decompression(s) and interbody fusion(s) for EITHER of the following:

- Recent (within 6 months) post-operative imaging studies of the cervical spine including flexion/extension lateral views demonstrating failure of a cervical disc arthroplasty implant (i.e., subsidence, loosening, dislocation/subluxation, vertebral body fracture without instability, dislodgement)
- Performed for **ANY** of the following conditions:
  - Unremitting neck pain when **ALL** of the following are met:
    - Significant level of pain on a daily basis defined as **EITHER** of the following:
      - Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
      - Severe, disabling, crippling, or incapacitating pain
    - Greater than 6 months since prior cervical disc arthroplasty procedure
    - Absence of unmanaged significant behavioral health disorders (e.g. major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse)
    - Less than clinically meaningful improvement with prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks unless contraindicated
    - Recent (within 6 months) post-operative MRI/CT findings that are concordant with the patient's symptoms or physical examination findings
  - Radiculopathy when **ALL** of the following are met:
    - Greater than 6 months since the prior cervical disc arthroplasty procedure
    - Absence of unmanaged significant behavioral health disorders (e.g. major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse)
    - Subjective symptoms including **BOTH** of the following:

        - Significant level of pain on a daily basis defined as **EITHER** of the following:
            - Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
            - Severe, disabling, crippling, or incapacitating pain
        - Unremitting radicular pain to shoulder girdle and/or upper extremity resulting in disability
    - Objective physical examination findings including **ANY** of the following:
        - Dermatomal sensory deficit
        - Motor deficit (e.g. biceps, triceps weakness)
        - Reflex changes
        - Shoulder Abduction Relief Sign
        - Nerve root tension sign (e.g. Spurling's maneuver)
        - Unremitting radicular pain to shoulder girdle and/or upper extremity without concordant objective physical examination findings
    - Less than clinically meaningful improvement with any **TWO** of the following unless contraindicated:
        - Prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks
        - Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks
        - Epidural steroid injection(s)/selective nerve root block(s)
    - Recent (within 6 months) post-operative MRI/CT identifies nerve root impingement caused by herniated disc(s) or osteophytes that is concordant with the patient's symptoms or physical examination findings
- Myelopathy when **ALL** of the following are met:
    - Greater than 6 months since the prior cervical disc arthroplasty procedure
    - Absence of unmanaged significant behavioral health disorders (e.g. major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse)
    - Subjective symptoms including **ANY** of the following:
        - Upper/lower extremity weakness, numbness, or pain
        - Fine motor dysfunction (buttoning, handwriting, clumsiness of hands)
        - New-onset bowel or bladder dysfunction due to a neurocompressive pathology
        - Frequent falls
    - Objective physical examination findings including at least **TWO** of the following:
        - Grip and release test
        - Ataxic gait
        - Hyperreflexia
        - Hoffmann sign
        - Pathologic Babinski sign
        - Tandem walking test
        - Inverted brachial radial reflex
        - Increased muscle tone or spasticity
        - Clonus
        - Myelopathic hand

- Recent (within 6 months) post-operative MRI/CT findings that are concordant with the patient's symptoms or physical examination findings including **ANY** of the following:
  - MRI/CT demonstrates cervical spinal cord compression
  - MRI/CT identifies cervical spinal stenosis

CMM-602.4: Adjacent Segment Disease Secondary to Cervical Total Disc Arthroplasty

Cervical total disc arthroplasty for adjacent segment disease secondary to cervical total disc arthroplasty is considered **medically necessary** when **ALL** of the following are met:

- The patient has degenerative cervical disc disease with intractable radiculopathy and/or myelopathy, producing symptomatic nerve root and/or spinal cord compression due to herniated disc and/or osteophyte formation.
- The patient is skeletally mature.
- An FDA approved implant is used in accordance with FDA labeling:
  - **EITHER** of the following for two level cervical disc arthroplasty:
    - Mobi-C®
    - PRESTIGE LP®
- The planned implant(s) will be used in the reconstruction of cervical disc(s) at C3-C7, following discectomy
- Recent (within 6 months) imaging studies of the cervical spine including flexion/extension lateral views demonstrating successful cervical total disc arthroplasty at the adjacent level
- The prior total disc arthroplasty procedure at an adjacent level was performed at least 6 months prior.
- No previous surgeries on the disc(s) involved
- Absence of unmanaged significant behavioral health disorders (e.g. major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse)
- Performed for **EITHER** of the following conditions:
  - Radiculopathy when **ALL** of the following are met:
    - Subjective symptoms including **BOTH** of the following:
      - Significant level of pain on a daily basis defined as **EITHER** of the following:
        - Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
        - Severe, disabling, crippling, or incapacitating pain
      - Unremitting radicular pain to shoulder girdle and/or upper extremity resulting in disability
    - Objective physical examination findings including **ANY** of the following:
      - Dermatomal sensory deficit
      - Motor deficit (e.g. biceps, triceps weakness)

        - Reflex changes
        - Shoulder Abduction Relief Sign
        - Nerve root tension sign (e.g. Spurling's maneuver)
        - Unremitting radicular pain to shoulder girdle and/or upper extremity without concordant objective physical examination findings
    - Less than clinically meaningful improvement with at least **TWO** of the following unless contraindicated:
        - Prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks
        - Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks
        - Epidural steroid injection(s)/selective nerve root block(s)
    - Recent (within 6 months) MRI/CT identifies nerve root impingement caused by herniated disc(s) or osteophytes that is concordant with the patient's symptoms and physical examination findings
- Myelopathy when **ALL** of the following are met:
    - Subjective symptoms including **ANY** of the following:
        - Upper/lower extremity weakness, numbness, or pain
        - Fine motor dysfunction (buttoning, handwriting, clumsiness of hands)
        - New-onset bowel or bladder dysfunction due to a neurocompressive pathology
        - Frequent falls
    - Objective physical examination findings including at least **TWO** of the following:
        - Grip and release test
        - Ataxic gait
        - Hyperreflexia
        - Hoffmann sign
        - Pathologic Babinski sign
        - Tandem walking test
        - Inverted brachial radial reflex
        - Increased muscle tone or spasticity
        - Clonus
        - Myelopathic hand
    - Recent (within 6 months) MRI/CT findings that is concordant with the patient's symptoms or physical examination findings including **EITHER** of the following:
        - MRI/CT demonstrates cervical spinal cord compression
        - MRI/CT identifies cervical spinal stenosis

CMM-602.5: Non-Indications

- Cervical total disc arthroplasty for degenerative disc disease as the sole indication is considered **not medically necessary**.
- Cervical total disc arthroplasty is considered **experimental, investigational, or unproven** when **ANY** of the following are present:
  - Patient is under age 18 or over age 60
  - The patient had prior surgery at the treated level
  - The planned procedure includes the combined use of a prosthesis and spinal fusion (hybrid construct)
  - The patient had a prior fusion at an adjacent cervical level (hybrid construct)
  - The planned procedure will lead to cervical total disc arthroplasty at more than two (2) levels
  - Decreased bone mineral density defined by **ANY** of the following:
    - DEXA bone mineral T-score equal to or worse than -3.5
    - T-score equal to or worse than -2.5 with history of a vertebral compression fracture
    - DEXA bone mineral density T-score ≤ -1.0
  - Allergy or sensitivity to titanium, aluminum or vanadium
  - Chronic non-specific neck or arm pain of unknown etiology
  - Absence of radiculopathy or myelopathy
  -
  - Active systemic infection
  - Revision of an infected cervical disc arthroplasty
  - Rheumatoid arthritis or other autoimmune disease
  - Paget's disease, osteomalacia or any other metabolic bone disease
  - Severe poorly controlled diabetes mellitus requiring insulin treatment
  - There is radiological evidence of **ANY** of the following:
    - Clinically significant cervical instability on neutral resting or lateral flexion/extension plain X-rays, defined as kyphotic deformity/significant reversal of lordosis or spondylolisthesis (e.g. > 3.5 mm subluxation/translation or > 11 degrees angulation/rotational difference) from that of either adjacent spinal level
    - Significant cervical anatomical deformity or compromised vertebral bodies at the index level (e.g. ankylosing spondylitis, rheumatoid arthritis, or compromise due to current or past trauma)
    - Spinal metastases
    - Severe spondylosis at the level to be treated characterized by bridging osteophytes, marked reduction or absence of motion, or collapse of the intervertebral disc space of greater than 50% of its normal height
    - Severe facet joint arthropathy
    - Ossification of the posterior longitudinal ligament (OPLL)

CMM-602.6: Procedure (CPT®) Codes

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code's inclusion on this list does not necessarily indicate prior authorization is required.	
CPT®	**Code Description/Definition**
22856	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection), single interspace, cervical
+22858	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection), second level, cervical (List separately in addition to code for primary procedure)
22861	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical
22864	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical
+0095T	Removal of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (List separately in addition to code for primary procedure)
+0098T	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (List separately in addition to code for primary procedure)
This list may not be all inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the health plan and is based on the individual's policy or benefit entitlement structure as well as claims processing rules.	

CMM-602.7: References

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CMM-603: Electrical and Low Frequency Ultrasound Bone Growth Stimulation (Spine)

CMM-603.1: General Guidelines

- The determination of medical necessity for the performance of electrical bone growth stimulation is always made on a case-by-case basis.
- For prior authorization requirements, see **CMM-600.1: Prior Authorization Requirements**.

CMM-603.2: Indications

- Invasive (inserted at the time of surgery) or noninvasive (beginning at any time from the time of surgery until up to 6 months after surgery with the exception of this timeline for an urgent/emergent condition for spinal fusion surgery excluding primary or metastatic neoplastic disease) electrical bone growth stimulation may be considered **medically necessary** for spinal fusion surgery in patients at high risk for pseudarthrosis with **ONE or MORE** of the following risk factors for fusion failure when associated with an approved spinal fusion surgery:
  - Alcoholism
  - Body mass index (BMI) > 30
  - Diabetes, renal disease, or other metabolic diseases when bone healing is likely to be compromised
  - Glucocorticoid dependent
  - Grade III or worse lumbar/lumbosacral spondylolisthesis
  - Multi-level spinal fusion including three (3) or more vertebrae
  - Nutritional deficiency/malnutrition
  - One or more previously failed spinal fusion(s)
  - Osteoporosis defined as T-score of ≤ -2.5 on a recent (within one year) DEXA
  - Severe anemia
  - Smoking history
  - Immunocompromised status
- Noninvasive electrical bone growth stimulation is considered **medically necessary** as a treatment for patients with failed spinal fusion when **BOTH** of the following are met:
  - A minimum of 6 months has passed since the date of the original surgery
  - Serial plain X-rays or appropriate imaging studies confirm there is no evidence of progression of healing/consolidation of the spinal fusion for 3 months during the later portion of the 6 month post-fusion surgery period.
- Urgent/emergent conditions for spine fusion surgery are exceptions to the above timelines for invasive and noninvasive electrical bone growth stimulation excluding primary or metastatic neoplastic disease (See: CMM 601.1, 604.1, and 609.1)

CMM-603.3: Non-Indications

- Invasive and noninvasive electrical bone growth stimulation is considered **experimental, investigational, or unproven** for **ALL** of the following:
  - Acute or chronic lumbar spondylolysis (pars interarticularis defect) with or without spondylolisthesis
  -
  - Failed cervical or lumbar disc arthroplasty
  - Spinal malignancy
  - As nonsurgical treatment of an established pseudarthrosis
- Semi-invasive electrical bone growth stimulation and low-intensity ultrasound stimulation is considered **experimental, investigational, or unproven** for any spinal indication due to a lack of sufficient evidence of their effectiveness.

CMM-603.4: Procedure (CPT®) Codes

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code's inclusion on this list does not necessarily indicate prior authorization is required.

CPT®	Code Description/Definition
20974	Electrical stimulation to aid bone healing; noninvasive (nonoperative)
20975	Electrical stimulation to aid bone healing; invasive (operative)
20979	Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)
HCPCS Codes	**Code Description/Definition**
E0748	Osteogenesis stimulator; electrical, noninvasive, spinal applications
E0749	Osteogenesis stimulator; electrical, surgically implanted
E0760	Osteogenesis stimulator; low intensity ultrasound, non-invasive

This list may not be all inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the health plan and is based on the individual's policy or benefit entitlement structure as well as claims processing rules.

CMM-603.5: References

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CMM-604: Posterior Cervical Decompression (Laminectomy/Hemilaminectomy/ Laminoplasty) with or without Fusion

CMM-604.1: General Guidelines

- The determination of medical necessity for the performance of posterior cervical decompression with or without fusion is always made on a case-by-case basis.
- For prior authorization requirements, see **CMM-600.1: Prior Authorization Requirements**.
- The presence of urgent/emergent indications/conditions warrants definitive surgical treatment. Confirmatory advanced imaging studies are required. The following criteria are **NOT** required for confirmed urgent/emergent conditions:
  - Provider-directed non-surgical management
  - Proof of smoking cessation
  - Recent (within 6 months) plain X-rays of the cervical spine
  - Absence of unmanaged significant behavioral health disorders
- Urgent/emergent conditions for posterior cervical decompression with or without fusion include **ANY** of the following:
  - Acute/unstable traumatic spinal fractures or dislocations with or without neural compression
  - Central cord syndrome
  - Congenital cervical stenosis (AP canal diameter ≤ 10 mm)
  - Documentation of progressive neurological deficit on two separate physical examinations
  - Epidural hematoma
  - Infection (e.g. discitis, epidural abscess, osteomyelitis)
  - Myelopathy
  - Occipitocervical and/or Atlantoaxial (C1-C2) instability (non-traumatic) and/or spinal cord compression due to **ANY** of the following:
    - Rheumatoid arthritis
    - Congenital abnormality of occipitocervical/C1-C2 vertebrae
    - Os odontoideum
  - Ossification of the posterior longitudinal ligament at three (3) or more levels
  - Primary or metastatic neoplastic disease causing pathologic fracture, cord compression or instability
  - Severe or rapidly progressive symptoms of motor loss, bowel incontinence or bladder incontinence/retention due to a neurocompressive pathology
  - Vascular malformations (e.g. AVM)
  - Documentation of severe debilitating pain and/or dysfunction to the point of being incapacitated
- Urgent/emergent conditions for posterior cervical fusion without decompression include:
  - Flexion-extension plain X-rays demonstrate instability and include **ANY** of the following:
    - >3.5 mm sagittal plane translation
    - >20% sagittal plane translation of vertebral body width
    - >11 degrees relative sagittal plane angulation

CMM-604.2: Initial Primary Posterior Cervical Decompression (Laminectomy/Hemilaminectomy/Laminoplasty) with or without Posterior Fusion

Initial primary posterior cervical decompression (laminectomy/hemilaminectomy/ laminoplasty) with or without posterior fusion is considered medically necessary when ALL of the following are met:

- Recent (within 6 months) plain X-rays of the cervical spine including flexion/extension lateral views have been performed
- No previous surgeries on the disc(s) involved
- Absence of unmanaged significant behavioral health disorders (e.g. major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse)
- Performed for **ANY** of the following conditions:
  - Radiculopathy when **ALL** of the following are met:
    - Subjective symptoms including **BOTH** of the following:
      - Significant level of pain on a daily basis defined as **EITHER** of the following:
        - Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
        - Severe, disabling, crippling, or incapacitating pain
      - Unremitting radicular pain to shoulder girdle and/or upper extremity resulting in disability
    - Objective physical examination findings including **ANY** of the following:
      - Dermatomal sensory deficit
      - Motor deficit (e.g. biceps, triceps weakness)
      - Reflex changes
      - Shoulder Abduction Relief Sign
      - Nerve root tension sign (e.g. Spurling's maneuver)
      - Unremitting radicular pain to shoulder girdle and/or upper extremity without concordant objective physical examination findings
    - Less than clinically meaningful improvement with at least **TWO** of the following unless contraindicated:
      - Prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks
      - Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks
      - Epidural steroid injection(s)/selective nerve root block(s)
    - Recent (within 6 months) MRI/CT identifies nerve root impingement caused by herniated disc(s) and/or osteophytes that is concordant with the patient's symptoms and physical examination findings
    - Documentation of nicotine-free status with **EITHER** of the following, unless request is for decompression only:
      - Patient is a never-smoker

        - Patient has refrained from smoking, use of smokeless tobacco products, and/or nicotine replacement therapy for at least 6 weeks prior to planned surgery as evidenced by blood cotinine lab results of ≤ 10 ng/mL
- Myelopathy when **ALL** of the following are met:
    - Subjective symptoms including **ANY** of the following:
        - Upper/lower extremity weakness, numbness, or pain
        - Fine motor dysfunction (buttoning, handwriting, clumsiness of hands)
        - New-onset bowel or bladder dysfunction due to a neurocompressive pathology
        - Frequent falls
    - Objective physical examination findings including at least **TWO** of the following:
        - Grip and release test
        - Ataxic gait
        - Hyperreflexia
        - Hoffmann sign
        - Pathologic Babinski sign
        - Tandem walking test
        - Inverted brachial radial reflex
        - Increased muscle tone or spasticity
        - Clonus
        - Myelopathic hand
    - Recent (within 6 months) MRI/CT findings that are concordant with the patient's symptoms and physical examination findings including **EITHER** of the following:
        - MRI/CT demonstrates cervical spinal cord compression
        - MRI/CT identifies cervical spinal stenosis
- A concurrent stabilization procedure with corpectomy, laminectomy, or other procedure at the cervicothoracic junction (i.e., C7 and T1)
- A concurrent stabilization procedure with a laminectomy, especially at C2
- Subluxation and/or spinal cord compression in patients with rheumatoid arthritis or clinical conditions with an increased incidence of congenital and/or acquired cervical spinal instability (e.g. Down syndrome, mucopolysaccharidoses, spondyloepiphyseal dysplasia, pseudoachondroplasia, etc.)
- Multi-level spondylotic myelopathy without kyphosis
- Primary or metastatic tumor with associated cord compression and/or instability
- Other symptomatic instability or spinal cord/root compression requiring posterior fusion with **BOTH** of the following:
    - Patient unresponsive to a reasonable and medically appropriate course of conservative treatment (e.g. rest, medication, cervical collar)
    - Recent (within 6 months) imaging study demonstrating corresponding pathologic anatomy

CMM-604.3: Posterior Cervical Fusion without Decompression

Posterior cervical fusion without decompression is considered medically necessary when ALL of the following criteria are met:

- Absence of unmanaged significant behavioral health disorders (e.g. major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse)
- Performed for **ONE or MORE** of the following:
  - Symptomatic pseudarthrosis from a prior anterior or posterior fusion procedure
  - Symptomatic cervical spondylosis with instability as evidenced radiographically by **ONE or MORE** of the following:
    - Subluxation or translation of more than 3.5 mm on static lateral views or dynamic flexion/extension lateral plain X-rays
    - Sagittal plane angulation of more than 11 degrees between adjacent spinal segments
    - More than 4 mm of motion (subluxation) between the tips of the spinous processes on flexion/extension lateral plain X-rays
  - Klippel-Feil syndrome
  - Cervical instability in patients with Down syndrome, skeletal dysplasia, or connective tissue disorders
- Documentation of nicotine-free status with **EITHER** of the following:
  - Patient is a never-smoker
  - Patient has refrained from smoking, use of tobacco products, and/or nicotine replacement therapy for at least 6 weeks prior to planned surgery as evidenced by blood cotinine lab results of ≤ 10 ng/mL

CMM-604.4: Repeat Posterior Cervical Decompression with or without Posterior Cervical Fusion at the Same Level

Repeat posterior cervical decompression with or without posterior cervical fusion at the same level is considered medically necessary when there is recent (within 6 months) post-operative plain X-rays or CT evidence of implant/instrumentation or structural bone graft malposition or failure *OR* when ALL of the following criteria are met:

- Recent (within 6 months) post-operative MRI /CT confirms evidence of neural structure compression e.g.
- Greater than 12 weeks since last posterior cervical decompression with or without fusion surgery
- Initial relief of symptoms following previous posterior cervical decompression procedure at same level
- Recent (within 6 months) post-operative plain X-rays of the cervical spine including flexion/extension lateral views instability as evidenced by **ONE or MORE** of the following:
  - Subluxation or translation of more than 3.5 mm on static lateral views or dynamic flexion/extension lateral plain X-rays

- Sagittal plane angulation of more than 11 degrees between adjacent spinal segments
- More than 4 mm of motion (subluxation) between the tips of the spinous processes on flexion/extension lateral plain X-rays

- Absence of unmanaged significant behavioral health disorders (e.g. major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse)
- Performed for **EITHER** of the following conditions:
  - Radiculopathy when **ALL** of the following are met:
    - Subjective symptoms including **BOTH** of the following:
      - Significant level of pain on a daily basis defined as **EITHER** of the following:
        - Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
        - Severe, disabling, crippling, or incapacitating pain
      - Unremitting radicular pain to shoulder girdle and/or upper extremity resulting in disability
    - Objective physical examination findings including **ANY** of the following:
      - Dermatomal sensory deficit
      - Motor deficit (e.g. biceps, triceps weakness)
      - Reflex changes
      - Shoulder Abduction Relief Sign
      - Nerve root tension sign (e.g. Spurling's maneuver)
      - Unremitting radicular pain to shoulder girdle and/or upper extremity without concordant objective physical examination findings
    - Less than clinically meaningful improvement with at least **TWO** of the following unless contraindicated:
      - Prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks
      - Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks
      - Epidural steroid injection(s)/selective nerve root block(s)
    - Recent (within 6 months) post-operative MRI/CT identifies nerve root impingement caused by herniated disc(s) and/or osteophytes that is concordant with the patient's symptoms and physical examination findings
    - Documentation of nicotine-free status with **EITHER** of the following, unless request is for decompression only:
      - Patient is a never-smoker
      - Patient has refrained from smoking, use of smokeless tobacco products, and/or nicotine replacement therapy for at least 6 weeks prior to planned surgery as evidenced by blood cotinine lab results of ≤ 10 ng/mL
  - Myelopathy when **ALL** of the following are met:
    - Subjective symptoms including **ANY** of the following:
      - Upper/lower extremity weakness, numbness, or pain
      - Fine motor dysfunction (buttoning, handwriting, clumsiness of hands)
      - New-onset bowel or bladder dysfunction due to a neurocompressive pathology
      - Frequent falls

- Objective physical examination findings including at least **TWO** of the following:
  - Grip and release test
  - Ataxic gait
  - Hyperreflexia
  - Hoffmann sign
  - Pathologic Babinski sign
  - Tandem walking test
  - Inverted brachial radial reflex
  - Increased muscle tone or spasticity
  - Clonus
  - Myelopathic hand
- Recent (within 6 months) post-operative MRI/CT findings that are concordant with the patient's symptoms and physical examination findings including **EITHER** of the following:
  - MRI/CT demonstrates cervical spinal cord compression
  - MRI/CT identifies cervical spinal stenosis

CMM-604.5: Failed Cervical Disc Arthroplasty Implant

Posterior cervical decompression with or without posterior cervical fusion following failed cervical disc arthroplasty implant is considered medically necessary when there is a failed cervical disc arthroplasty implant diagnosed by recent (within 6 months) post-operative plain film, CT and/or CT myelogram (i.e., subsidence, loosening, infection, dislocation/subluxation, vertebral body fracture, dislodgement)
OR when ALL of the following criteria are met:

- Recent (within 6 months) post-operative MRI/CT findings that correlate with the patient's symptoms or physical examination findings demonstrating neural structure compression
- Greater than 12 weeks since the cervical disc arthroplasty
- Initial relief of symptoms following previous cervical disc arthroplasty at the same level
- Absence of unmanaged significant behavioral health disorders (e.g. major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse)
- Performed for **EITHER** of the following conditions:
  - Radiculopathy when **ALL** of the following are met:
    - Subjective symptoms including **BOTH** of the following:
      - Significant level of pain on a daily basis defined as **EITHER** of the following:
        - Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
        - Severe, disabling, crippling, or incapacitating pain
      - Unremitting radicular pain to shoulder girdle and/or upper extremity resulting in disability
    - Objective physical examination findings including **ANY** of the following:

        - Dermatomal sensory deficit
        - Motor deficit (e.g. biceps, triceps weakness)
        - Reflex changes
        - Shoulder Abduction Relief Sign
        - Nerve root tension sign (e.g. Spurling's maneuver)
        - Unremitting radicular pain to shoulder girdle and/or upper extremity without concordant objective physical examination findings
    - Less than clinically meaningful improvement with at least **TWO** of the following unless contraindicated:
        - Prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks
        - Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks
        - Epidural steroid injection(s)/selective nerve root block(s)
    - Documentation of nicotine-free status with **EITHER** of the following, unless request is for decompression only:
        - Patient is a never-smoker
        - Patient has refrained from smoking, use of smokeless tobacco products, and/or nicotine replacement therapy for at least 6 weeks prior to planned surgery as evidenced by blood cotinine lab results of ≤ 10 ng/mL
- Myelopathy when **ALL** of the following are met:
    - Subjective symptoms including **ANY** of the following:
        - Upper/lower extremity weakness, numbness, or pain
        - Fine motor dysfunction (buttoning, handwriting, clumsiness of hands)
        - New-onset bowel or bladder dysfunction due to a neurocompressive pathology
        - Frequent falls
    - Objective physical examination findings including at least **TWO** of the following:
        - Grip and release test
        - Ataxic gait
        - Hyperreflexia
        - Hoffmann sign
        - Pathologic Babinski sign
        - Tandem walking test
        - Inverted brachial radial reflex
        - Increased muscle tone or spasticity
        - Clonus
        - Myelopathic hand

CMM-604.6: Non-Indications

Posterior cervical decompression (laminectomy, hemilaminectomy, and laminoplasty) with or without posterior fusion is considered not medically necessary for ANY of the following sole indications:

- Signs and symptoms with no correlation to imaging studies
- Annular tears
- Disc bulge with no neural impingement or cord compression on imaging
- Concordant discography
- Degenerative disc disease
- Isolated facet fusion, with or without instrumentation, including allograft bone graft substitutes used exclusively as stand-alone stabilization devices (e.g. DTRAX® (cervical), TruFuse (any level), NuFix® (any level))

CMM-604.7: Procedure (CPT®) Codes

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code's inclusion on this list does not necessarily indicate prior authorization is required.

CPT®	Code Description/Definition
22590	Arthrodesis, posterior technique, craniocervical (occiput-C2)
22595	Arthrodesis, posterior technique, atlas-axis (C1-C2)
22600	Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment
+22614	Each additional vertebral segment (List separately in addition to code for primary procedure)
+22841	Internal spinal fixation by wiring of spinous processes (List separately in addition to code for primary procedure)
+22842	Posterior segmental instrumentation (e.g. pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure)
+22843	Posterior segmental instrumentation (e.g. pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral segments (List separately in addition to code for primary procedure)
63001	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g. spinal stenosis), 1 or 2 vertebral segments; cervical
63015	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g. spinal stenosis), more than 2 vertebral segments; cervical
63045	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g. spinal or lateral recess stenosis]), single vertebral segment; cervical

+63048	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g. spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)
63050	Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments;
63051	Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments; with reconstruction of the posterior bony elements (including the application of bridging bone graft and non-segmental fixation devices (e.g. wire, suture, mini-plates), when performed)
63265	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; cervical
63270	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; cervical
63275	Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, cervical
63280	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, extramedullary, cervical
63285	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, cervical
63290	Laminectomy for biopsy/excision of intraspinal neoplasm; combined extradural-intradural lesion, any level
+63295	Laminectomy for biopsy/excision of intraspinal neoplasm; osteoplastic reconstruction of dorsal spinal elements, following primary intraspinal procedure (List separately in addition to code for primary procedure)
This list may not be all inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the health plan and is based on the individual's policy or benefit entitlement structure as well as claims processing rules.	

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CMM-605: Cervical Microdiscectomy

CMM-605.1: General Guidelines

- The determination of medical necessity for the performance of cervical microdiscectomy is always made on a case-by-case basis.
- For prior authorization requirements, see **CMM-600.1: Prior Authorization Requirements**.
- The presence of urgent/emergent indications/conditions warrants definitive surgical treatment. Confirmatory advanced imaging studies are required. The following criteria are **NOT** required for confirmed urgent/emergent conditions:
  - Provider-directed non-surgical management
  - Absence of unmanaged significant behavioral health disorders
- Urgent/emergent conditions for cervical microdiscectomy include **ANY** of the following:
  - Myelopathy
  - Central cord syndrome
  - Documentation of progressive neurological deficit on two separate physical examinations
  - Severe or rapidly progressive symptoms of motor loss, bowel incontinence or bladder incontinence/retention due to a neurocompressive pathology
  - Documentation of severe debilitating pain and/or dysfunction to the point of being incapacitated

CMM-605.2: Initial Primary Cervical Microdiscectomy

Initial primary cervical microdiscectomy is considered medically necessary when ALL of the following are met:

- No previous surgeries on the disc(s) involved
- Absence of unmanaged significant behavioral health disorders (e.g. major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse)
- Performed for **EITHER** of the following conditions:
  - Radiculopathy when **ALL** of the following are met:
    - Subjective symptoms including **BOTH** of the following:
      - Significant level of pain on a daily basis defined as **EITHER** of the following:
        - Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
        - Severe, disabling, crippling, or incapacitating pain
      - Unremitting radicular pain to shoulder girdle and/or upper extremity resulting in disability
    - Objective physical examination findings including **ANY** of the following:
      - Dermatomal sensory deficit
      - Motor deficit (e.g. biceps, triceps weakness)
      - Reflex changes
      - Shoulder Abduction Relief Sign
      - Nerve root tension sign (e.g. Spurling's maneuver)

        - Unremitting radicular pain to shoulder girdle and/or upper extremity without concordant objective examination findings
    - Less than clinically meaningful improvement with at least **TWO** of the following unless contraindicated:
        - Prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks
        - Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks
        - Epidural steroid injection(s)/selective nerve root block(s)
    - Recent (within 6 months) MRI/CT identifies nerve root impingement caused by herniated disc(s) and/or osteophytes that is concordant with the patient's symptoms and physical examination findings
- Myelopathy when **ALL** of the following are met:
    - Subjective symptoms including **ANY** of the following:
        - Upper/lower extremity weakness, numbness, or pain
        - Fine motor dysfunction (buttoning, handwriting, clumsiness of hands)
        - New-onset bowel or bladder dysfunction due to a neurocompressive pathology
        - Frequent falls
    - Objective physical examination findings including at least **TWO** of the following:
        - Grip and release test
        - Ataxic gait
        - Hyperreflexia
        - Hoffmann sign
        - Pathologic Babinski sign
        - Tandem walking test
        - Inverted brachial radial reflex
        - Increased muscle tone or spasticity
        - Clonus
        - Myelopathic hand
    - Recent (within 6 months) MRI/CT findings that are concordant with the patient's symptoms and physical examination findings including **EITHER** of the following:
        - MRI/CT demonstrates cervical spinal cord compression
        - MRI/CT identifies cervical spinal stenosis

CMM-605.3: Repeat Cervical Microdiscectomy at the Same Level

Repeat cervical microdiscectomy at the same level is considered medically necessary when ALL of the following are met:

- Recent (within 6 months) post-operative MRI /CT confirms evidence of neural structure compression (e.g. either retained disc material or a recurrent disc herniation)
- Greater than 12 weeks since the initial primary cervical microdiscectomy
- Initial relief of symptoms following previous disc decompression procedure at the same level
- Absence of unmanaged significant behavioral health disorders (e.g. major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse)
- Performed for **EITHER** of the following conditions:
  - Radiculopathy when **ALL** of the following are met:
    - Subjective symptoms including **BOTH** of the following:
      - Significant level of pain on a daily basis defined as **EITHER** of the following:
        - Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
        - Severe, disabling, crippling, or incapacitating pain
      - Unremitting radicular pain to shoulder girdle and/or upper extremity resulting in disability
    - Objective physical examination findings including **ANY** of the following:
      - Dermatomal sensory deficit
      - Motor deficit (e.g. biceps, triceps weakness)
      - Reflex changes
      - Shoulder Abduction Relief Sign
      - Nerve root tension sign (e.g. Spurling's maneuver)
      - Unremitting radicular pain to shoulder girdle and/or upper extremity without concordant objective physical examination findings
    - Less than clinically meaningful improvement with at least **TWO** of the following unless contraindicated:
      - Prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks
      - Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks
      - Epidural steroid injection(s)/selective nerve root block(s)
  - Myelopathy when **ALL** of the following are met:
    - Subjective symptoms including **ANY** of the following:
      - Upper/lower extremity weakness, numbness, or pain
      - Fine motor dysfunction (buttoning, handwriting, clumsiness of hands)
      - New-onset bowel or bladder dysfunction due to a neurocompressive pathology
      - Frequent falls

- Objective physical examination findings including at least **TWO** of the following:
  - Grip and release test
  - Ataxic gait
  - Hyperreflexia
  - Hoffmann sign
  - Pathologic Babinski sign
  - Tandem walking test
  - Inverted brachial radial reflex
  - Increased muscle tone or spasticity
  - Clonus
  - Myelopathic hand

CMM-605.4: Non-Indications

Cervical microdiscectomy for ANY of the following sole indications is considered not medically necessary:

- Signs and symptoms with no correlation to imaging studies
- Annular tears
- Disc bulge with no neural impingement or cord compression on imaging
- Concordant discography
- Degenerative disc disease

CMM-605.5: Procedure (CPT®) Codes

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code's inclusion on this list does not necessarily indicate prior authorization is required.

CPT®	Code Description/Definition
63020	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical
+63035	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)
63040	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; cervical
+63043	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional cervical interspace (List separately in addition to code for primary procedure)

This list may not be all inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the health plan and is based on the individual's policy or benefit entitlement structure as well as claims processing rules.

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CMM-606: Lumbar Microdiscectomy (Laminotomy, Laminectomy, or Hemilaminectomy)

CMM-606.1: General Guidelines

- The determination of medical necessity for the performance lumbar microdiscectomy and excision of extradural lesion other than neoplasm is always made on a case-by-case basis.
- For prior authorization requirements, see **CMM-600.1: Prior Authorization Requirements**.
- The presence of urgent/emergent indications/conditions warrants definitive surgical treatment. Confirmatory advanced imaging studies are required. The following criteria are NOT required for confirmed urgent/emergent conditions:
  - Provider-directed non-surgical management
  - Recent (within 6 months) plain X-rays of the lumbar spine
  - Absence of unmanaged significant behavioral health disorders
- Urgent/emergent conditions for lumbar microdiscectomy and excision of extradural lesion other than neoplasm include **ANY** of the following[2]:
  - Cauda equina syndrome (CES)
  - Documentation of progressive neurological deficit on two separate physical examinations
  - Epidural hematoma
  - Infection (e.g. discitis, epidural abscess, osteomyelitis)
  - Primary or metastatic neoplastic disease causing pathologic fracture, cord compression or instability
  - Severe or rapidly progressive symptoms of motor loss, bowel incontinence or bladder incontinence/retention due to a neurocompressive pathology
  - Documentation of severe debilitating pain and/or dysfunction to the point of being incapacitated

CMM-606.2: Initial Primary Lumbar Microdiscectomy (Laminotomy, Laminectomy or Hemilaminectomy)

Initial primary lumbar microdiscectomy (laminotomy, laminectomy, or hemilaminectomy) is considered medically necessary when ALL of the following are met:

- Performed for **ANY** of the following:
  - Radiculopathy/neurogenic claudication secondary to herniated disc
  - Synovial cyst/arachnoid cyst
  - Central/lateral/foraminal stenosis
- No previous surgeries on the disc(s) involved
- All other sources of pain have been excluded
- Absence of unmanaged significant behavioral health disorders (e.g. major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse)
- Subjective symptoms including at least **TWO** of the following:
  - Significant level of pain on a daily basis defined as **EITHER** of the following:
    - Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7

        - Severe, disabling, crippling, or incapacitating pain
    - Persistent radiating pain into the buttock(s) and/or lower extremity(ies) on a daily basis that has a documented negative impact on activities of daily living despite optimal conservative treatment as described below
    - Pain, cramping, weakness, or tingling in the lower back, buttock(s), and leg(s) brought about by walking or positions that cause thecal sac or nerve root compression (e.g. standing, extension)
- Objective physical examination findings including **EITHER** of the following:
    - Nerve root tension sign including **ANY** of the following:
        - Positive straight leg raise
        - Crossed straight leg raise
        - Femoral stretch test
    - Neurologic deficit including **ANY** of the following:
        - Dermatomal sensory deficit
        - Functionally limiting motor weakness (e.g. foot drop, quadriceps weakness)
        - Reflex changes
- Recent (within 6 months) MRI/CT identifies nerve root impingement and/or thecal sac impingement that is concordant with patient symptoms and physical examination findings and is caused by **ONE OR MORE** of the following:
    - Herniated disc(s)
    - Synovial cyst or arachnoid cyst
    - Central/lateral/foraminal stenosis
- Less than clinically meaningful improvement with at least **TWO** of the following unless contraindicated:
    - Prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks
    - Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks
    - Epidural steroid injection(s)/selective nerve root block(s)

CMM-606.3: Repeat Lumbar Microdiscectomy (Laminotomy or Laminectomy) at the Same Level

Repeat lumbar microdiscectomy (laminotomy or laminectomy) at the same level is considered medically necessary when ALL of the following are met:

- Recent (within 6 months) post-operative MRI /CT confirms evidence of neural structure compression (e.g. either retained disc material or a recurrent disc herniation)
- Greater than 12 weeks since initial lumbar disc decompression surgery
- Initial relief of symptoms following previous disc decompression procedure at the same level unless recent (within 6 months) post-operative imaging demonstrates persistent significant neurologic compression at the surgical level
- Performed for **ANY** of the following:
    - Radiculopathy/neurogenic claudication secondary to herniated disc
    - Synovial cyst/arachnoid cyst

- Central/lateral/foraminal stenosis

- All other sources of pain have been excluded
- Absence of unmanaged significant behavioral health disorders (e.g. major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse)
- Subjective symptoms including at least **TWO** of the following:
  - Significant level of pain on a daily basis defined as **EITHER** of the following:
    - Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
    - Severe, disabling, crippling, or incapacitating pain
  - Persistent radiating pain into the buttock(s) and/or lower extremity(ies) on a daily basis that has a documented negative impact on activities of daily living despite optimal conservative treatment as described below
  - Pain, cramping, weakness, or tingling in the lower back, buttock(s), and leg(s) brought about by walking or positions that cause thecal sac or nerve root compression (e.g. standing, extension)
- Objective physical examination findings including **EITHER** of the following:
  - Nerve root tension sign including **ANY** of the following:
    - Positive straight leg raise
    - Crossed straight leg raise
    - Femoral stretch test
  - Neurologic deficit including **ANY** of the following:
    - Dermatomal sensory deficit
    - Functionally limiting motor weakness (e.g. foot drop, quadriceps weakness)
    - Reflex changes
- Less than clinically meaningful improvement with at least **TWO** of the following unless contraindicated:
    - Prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks
    - Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks
    - Epidural steroid injection(s)/selective nerve root block(s)

CMM-606.4: Non-Indications

- The performance of lumbar microdiscectomy (laminotomy, laminectomy, and hemilaminectomy) with laser technique is considered **not medically necessary**.
- Initial and repeat lumbar microdiscectomy (laminotomy, laminectomy, and hemilaminectomy) is considered **not medically necessary** for **ANY** of the following sole indications:
  - Subjective symptoms and objective physical examination findings that are not concordant with imaging
  - Predominate lower back pain associated with disc degeneration with or without annular tears in the absence of a disc herniation
  - Patients who are asymptomatic with a normal physical examination regardless of the size of the disc herniation
  - Disc bulge with no neural impingement or cord compression on imaging
  - Concordant discography
  - Isolated axial lower back pain in the presence of disc herniation
- Endoscopic and/or percutaneous laser disc decompression of spinal cord nerve root(s) is considered **experimental, investigational, or unproven**.

CMM-606.5: Procedure (CPT®) Codes

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code's inclusion on this list does not necessarily indicate prior authorization is required.

CPT®	Code Description/Definition
62380	Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar
+63035	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)
63042	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar
+63044	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional lumbar interspace (List separately in addition to code for primary procedure)
63056	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (e.g. herniated intervertebral disc), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (e.g. far lateral herniated intervertebral disc)
+63057	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (e.g. herniated intervertebral disc), single segment; each additional segment, thoracic or lumbar (List separately in addition to code for primary procedure)

63267	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; lumbar
63272	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; lumbar
63277	Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, lumbar
S2350	Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; lumbar, single interspace
+S2351	Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; lumbar, each additional interspace (list separately in addition to code for primary procedure)
This list may not be all inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the health plan and is based on the individual's policy or benefit entitlement structure as well as claims processing rules.	

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CMM-607: Primary Vertebral Augmentation (Percutaneous Vertebroplasty/Kyphoplasty) and Sacroplasty

CMM-607.1: General Guidelines

- The determination of medical necessity for the performance of vertebral augmentation (percutaneous vertebroplasty/kyphoplasty) and sacroplasty is always made on a case-by-case basis.
- For prior authorization requirements, see **CMM-600.1: Prior Authorization Requirements**.
- The presence of urgent/emergent indications/conditions warrants definitive surgical treatment. Confirmatory advanced imaging studies are required. The following criteria are **NOT** required for confirmed urgent/emergent conditions:
  - Provider-directed non-surgical management
- Urgent/emergent conditions for vertebral augmentation procedure include **EITHER** of the following:
  - Primary or metastatic neoplastic disease causing pathologic fracture
  - Documentation of severe debilitating pain and/or dysfunction to the point of being incapacitated

CMM-607.2: Indications

Vertebral augmentation (injection of methylmethacrylate cement under imaging guidance) is considered medically necessary when ALL of the following are met:

- Performed for **ANY** of the following conditions which is concordant with recent (within 6 months) confirmatory imaging:
  - Osteolytic or osteoporotic vertebral compression fracture with persistent and debilitating pain
  - Osteolytic metastases including destruction of a vertebral body by multiple myeloma
  - Primary malignant neoplasm of bone or bone marrow
  - Painful and/or aggressive space occupying lesions of a vertebral body (hemangioma/eosinophilic granuloma)
  - Pre-surgical stabilization of a vertebral body to facilitate a fusion operation
  - Painful osteonecrotic (i.e., Kummel disease) vertebral compression fracture
  - Steroid induced vertebral compression fracture
- Persistent debilitating pain including **BOTH** of the following:
  - Significant level of pain on a daily basis defined as **EITHER** of the following:
    - Visual Analog Scale (VAS)/Number Rating Scale (NRS) ≥ 7
    - Severe, disabling, crippling, or incapacitating pain
  - Clinically significant functional impairment (e.g. inability to perform household chores, prolonged standing or essential job functions)
- **EITHER** of the following:
  - Acute (0-6 weeks) axial back pain that persists at a level which prevents independent transfers and/or ambulation and correlates with the level of the fracture
  - Subacute (> 6 weeks) axial pain in the thoracic/lumbar spine for at least 4 weeks including the following:

    - Less than clinically meaningful improvement with **BOTH** of the following unless contraindicated:
        - Prescription strength analgesics, steroids, and/or NSAIDs for 4 weeks
        - Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 4 weeks

- Documentation of a recent (within 6 months) compression fracture with **ANY** of the following:
    - Uptake on a nuclear medicine bone scan
    - Increased intensity on fluid sensitive MRI sequences
    - Plain x-ray
    - CT
- Performed at no more than 2 levels of the T5-L5 spine on the same date of service

CMM-607.3: Non-Indications

Vertebral Augmentation (Percutaneous Vertebroplasty/Kyphoplasty) is considered not medically necessary for EITHER of the following:

- The presence of **ANY** of the following contraindications:
    - Allergy to materials used in the procedure
    - Uncorrected coagulation disorders or anticoagulation therapy
    - Myelopathy associated with a bone fragment in the spinal canal or cord compression from a tumor
    - Extensive vertebral destruction
    - Burst fracture associated with widened pedicles and/or retropulsed bone fragments
    - Potential space occupying lesions causing cord compression (tumor, bone fragment)
    - Collapse of vertebral body to less than the level of the vertebra plana
    - The use of Norian XR cement and Norian SRS cement products is prohibited because they are not FDA approved
    - Radiculopathy from a herniated intervertebral disc
    - Untreated symptomatic foraminal or canal stenosis, facet arthropathy, or other significant coexistent spinal or bony pain generators
    - Unstable fracture or requirement for stabilization procedure in the same or adjacent spinal region
    - Septicemia and any active infection (including urinary tract infection [UTI])
    - Active osteomyelitis of the target vertebra
    - Severe cardiopulmonary disease
    - Lack of credentialed spine surgeon to perform an urgent laminectomy in the event of cement extravasation into the spinal canal
    - Applications in the cervical spine
- The presence of **ANY** of the following alternative causes of axial back pain:
    - Lumbar/thoracic radiculopathy or facet disease
    - Lumbar/thoracic/sacral trigger points
    - Sacral insufficiency fractures

Primary Vertebral Augmentation (Percutaneous Vertebroplasty/Kyphoplasty) is considered experimental, investigational, or unproven for EITHER of the following:

- Percutaneous vertebral augmentation for **ANY** of the following:
  - Non-painful/non-aggressive vertebral hemangioma
  - Vertebrae of the cervical spine and thoracic levels T1-T4
  - Stabilization of insufficiency fractures or lesions of the sacrum (sacroplasty) or coccyx (coccygeoplasty)
  - Prophylactic treatment for osteoporosis of the spine
  - Prophylactic treatment for chronic back pain of longstanding duration (>6 months), even if associated with old compression fracture(s)
- Spinoplasty (e.g. OptiMesh® 1500E Polyethylene Terephthalate (PET) mesh pouch)

CMM-607.4: Procedure (CPT®) Codes

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code's inclusion on this list does not necessarily indicate prior authorization is required.

CPT®	Code Description/Definitions
22510	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic
22511	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral
+22512	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure)
22513	Percutaneous Vertebral Augmentation, Including Cavity Creation (Fracture Reduction and Bone Biopsy Included When Performed) Using Mechanical Device, (e.g. Kyphoplasty); 1 Vertebral Body, Unilateral or Bilateral Cannulation, Inclusive Of All Imaging Guidance; Thoracic
22514	Percutaneous Vertebral Augmentation, Including Cavity Creation (Fracture Reduction and Bone Biopsy Included When Performed) Using Mechanical Device, (e.g. Kyphoplasty); 1 Vertebral Body, Unilateral or Bilateral Cannulation, Inclusive Of All Imaging Guidance; Lumbar
+22515	Percutaneous Vertebral Augmentation, Including Cavity Creation (Fracture Reduction and Bone Biopsy Included When Performed) Using Mechanical Device, (e.g. Kyphoplasty); 1 Vertebral Body, Unilateral or Bilateral Cannulation, Inclusive Of All Imaging Guidance; Each Additional Thoracic or Lumbar Vertebral Body (List Separately in Addition to Code for Primary Procedure)

This list may not be all inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the health plan and is based on the individual's policy or benefit entitlement structure as well as claims processing rules.

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CMM-608: Lumbar Decompression

CMM-608.1: General Guidelines

- The determination of medical necessity for the performance of lumbar decompression is always made on a case-by-case basis.
- For prior authorization requirements, see **CMM-600.1: Prior Authorization Requirements**.
- The presence of urgent/emergent indications/conditions warrants definitive surgical treatment. Confirmatory advanced imaging studies are required. The following criteria are **NOT** required for confirmed urgent/emergent conditions:
  - Provider-directed non-surgical management
  - Absence of unmanaged significant behavioral health disorders
- Urgent/emergent conditions for lumbar decompression include **ANY** of the following:
  - Acute/unstable traumatic spinal fractures or dislocations with or without neural compression
  - Cauda equina syndrome (CES)
  - Epidural hematoma
  - Documentation of progressive neurological deficit on two separate physical examinations
  - Infection (e.g. discitis, epidural abscess, osteomyelitis)
  - Primary or metastatic neoplastic disease causing pathologic fracture, cord compression or instability
  - Severe or rapidly progressive symptoms of motor loss, bowel incontinence or bladder incontinence/retention due to a neurocompressive pathology
  - Documentation of severe debilitating pain and/or dysfunction to the point of being incapacitated

CMM-608.2: Initial Primary Lumbar Decompression

Initial primary lumbar decompression is considered medically necessary when ALL of the following are met:

- No previous surgeries at the level(s) involved
- All other sources of pain have been excluded
- Absence of unmanaged significant behavioral health disorders (e.g. major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse)
- Subjective symptoms including at least **TWO** of the following:
  - Significant level of pain on a daily basis defined as **EITHER** of the following:
    - Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
    - Severe, disabling, crippling, or incapacitating pain
  - Persistent radiating pain into the buttock(s) and/or lower extremity(ies) on a daily basis that has a documented negative impact on activities of daily living despite optimal conservative treatment as described below
  - Pain, cramping, weakness, or tingling in the lower back, buttock(s), and leg(s) brought about by walking or positions that cause thecal sac or nerve root compression (e.g. standing, extension)

- Performed for **EITHER** of the following:
  - Neurogenic claudication secondary to central/lateral recess/foraminal stenosis when **BOTH** of the following are met:
    - Subjective symptoms including **EITHER** of the following:
      - Symptoms worsen with standing and/or walking
      - Symptoms are alleviated with sitting and/or forward flexion
    - Objective physical examination findings concordant with recent (within 6 months) MRI/CT
  - Spondylolisthesis with neurogenic claudication symptoms or radicular pain from lateral recess or foraminal stenosis associated with listhesis demonstrated on plain x-rays and/or MRI/CT
- Less than clinically meaningful improvement with at least **TWO** of the following unless contraindicated:
  - Prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks
  - Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks
  - Epidural steroid injection(s)/selective nerve root block(s)
- Recent (within 6 months) MRI/CT identifies nerve root impingement and/or thecal sac impingement caused by stenosis/listhesis that is concordant with patient symptoms and/or physical examination findings

CMM-608.3: Repeat Lumbar Decompression at the Same Level

Repeat lumbar decompression at the same level is considered medically necessary when ALL of the following is met:

- Recent (within 6 months) post-operative MRI /CT confirms radiographic evidence of neural structure compression (e.g. nerve root(s) compression)
- Greater than 12 weeks since last decompression surgery
- Initial relief of symptoms following previous decompression procedure at the same level(s) unless recent (within 6 months) post-operative imaging demonstrates persistent significant neurologic compression at the surgical level
- All other sources of pain have been excluded
- Absence of unmanaged significant behavioral health disorders (e.g. major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse)
- Subjective symptoms including at least **TWO** of the following:
  - Significant level of pain on a daily basis defined as **EITHER** of the following:
    - Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
    - Severe, disabling, crippling, or incapacitating pain
  - Persistent radiating pain into the buttock(s) and/or lower extremity(ies) on a daily basis that has a documented negative impact on activities of daily living despite optimal conservative treatment as described below

- Pain, cramping, weakness, or tingling in the lower back, buttock(s), and leg(s) brought about by walking or positions that cause thecal sac or nerve root compression (e.g. standing, extension)

- Performed for **EITHER** of the following:
  - Neurogenic claudication secondary to central/lateral recess/foraminal stenosis when **ALL** of the following are met:
    - Subjective symptoms including **EITHER** of the following:
      - Symptoms worsen with standing and/or walking
      - Symptoms are alleviated with sitting and/or forward flexion
    - Objective physical examination findings concordant with recent (within 6 months) post-operative MRI/CT
  - Spondylolisthesis with neurogenic claudication symptoms or radicular pain from lateral recess, or foraminal stenosis associated with listhesis demonstrated on plain x-rays and/or MRI/CT

- Less than clinically meaningful improvement with at least **TWO** of the following unless contraindicated:
  - Prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks
  - Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks
  - Epidural steroid injection(s)/selective nerve root block(s)

CMM-608.4: Non-Indications

- **ANY** of the following procedures are considered **experimental, investigational, or unproven**:
  - Percutaneous lumbar discectomy
  - Percutaneous laser discectomy
  - Laser-assisted disc decompression
  - Percutaneous laser disc decompression
  - Percutaneous nucleotomy
  - Minimally invasive lumbar decompression (MILD)
  - Minimally invasive thoracic discectomy for the treatment of axial spinal pain
  - Percutaneous endoscopic discectomy

- Interspinous/interlaminar process spacer devices (ISS) and interspinous/interlaminar stabilization/distraction devices, and interspinous process decompression (IPD) systems/devices (e.g. Coflex Interlaminar Technology Implant, Superion ISS Interspinous Spacer System, X-STOP Interspinous Process Decompression System, X-STOP PEEK Interspinous Process Decompression System) are considered **experimental, investigational and/or unproven** for **ALL** indications including, but not limited to:
  - Lumbar interspinous/interlaminar distraction without fusion for indirect spinal decompression
  - Lumbar interspinous fixation with fusion with or without decompression for stabilization
  - Lumbar spinal stabilization with an interspinous process device/interlaminar device without fusion in conjunction with decompression laminectomy

CMM-608.5: Procedure (CPT®) Codes

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code's inclusion on this list does not necessarily indicate prior authorization is required.

CPT®	Code Description/Definitions
22867	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level
+22868	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure)
22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level
+22870	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)
63005	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g. spinal stenosis), 1 or 2 vertebral segments; lumbar, except for spondylolisthesis
63011	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; sacral
63012	Laminectomy with removal of abnormal facets and/or pars inter-articularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure)
63017	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g. spinal stenosis), more than 2 vertebral segments; lumbar
63047	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), [e.g. Spinal or lateral recess stenosis]), single vertebral segment; lumbar
63048	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g. spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)
0274T	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (e.g. fluoroscopic, CT), single or multiple levels, unilateral or bilateral; cervical or thoracic
0275T	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy) any method under indirect image guidance (e.g. fluoroscopic, CT), single or multiple levels, unilateral or bilateral; lumbar

This list may not be all inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the health plan and is based on the individual's policy or benefit entitlement structure as well as claims processing rules.

CMM-608.6: References

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CMM-609: Lumbar Fusion (Arthrodesis)

CMM-609.1: General Guidelines

- The determination of medical necessity for the performance of lumbar fusion (arthrodesis) is always made on a case-by-case basis.
- Adult spinal deformity surgery does not require documentation of any of the following:
  - Spinal instability and/or spondylolisthesis
  - Failure of provider-directed non-surgical management
- For prior authorization requirements, see **CMM-600.1: Prior Authorization Requirements**.
- The presence of urgent/emergent indications/conditions warrants definitive surgical treatment. Confirmatory advanced imaging studies are required. The following criteria are **NOT** required for confirmed urgent/emergent conditions:
  - Provider-directed non-surgical management
  - Proof of smoking cessation
  - Absence of unmanaged significant behavioral health disorders
- Urgent/emergent conditions for thoracolumbar fusion (arthrodesis) include **ANY** of the following:
  - Infection (e.g. discitis, epidural abscess, osteomyelitis) when instability is present or debridement and/or decompression is anticipated to result in instability
  - Primary or metastatic neoplastic disease causing pathologic fracture, cord compression, when instability is present or resection and/or decompression is anticipated to result in instability
  - Congenital, neuromuscular, or infantile/juvenile/adolescent idiopathic scoliosis
  - Traumatic spinal fractures or dislocations with or without neural compression when instability is present or decompression of the spinal canal is anticipated to result in instability
  - Documentation of severe debilitating pain and/or dysfunction to the point of being incapacitated

CMM-609.2: Lumbar Fusion (Arthrodesis)

Lumbar fusion (arthrodesis) with decompression is considered medically necessary when ALL of the following are met:

- The patient is a candidate for lumbar decompression. Refer to **CMM-608: Lumbar Decompression**.
- Performed for actual or anticipated iatrogenic instability from decompression and when **EITHER** of the following are met:
  - Actual or anticipated instability identified intra-operatively created by disruption of the posterior elements due to facet joint excision that exceeds 50% bilaterally or 75% or more of a single facet during spinal decompression
  - Confirmatory imaging including **ANY** of the following (not required when instability is created and/or identified intra-operatively):
    - Recent (within 6 months) imaging documenting postoperative instability created by the disruption of the posterior elements due to facet joint excision that exceeds 50% bilaterally or 75% or more of a single facet
    - Removal of the pars interarticularis is performed that requires fusion to stabilize
    - Pars fracture
    - Previous spinal decompression that resulted in iatrogenic spondylolisthesis
- Absence of untreated, underlying psychological conditions/issues (e.g. depression, chronic pain syndrome, secondary gain, drug and alcohol abuse, etc.) as a contributor to chronic pain
- Documentation of nicotine-free status with **EITHER** of the following:
  - Patient is a never-smoker
  - Patient has refrained from smoking, use of smokeless tobacco products, and/or nicotine replacement therapy for at least 6 weeks prior to planned surgery as evidenced by blood cotinine lab results of ≤ 10 ng/mL

Lumbar fusion (arthrodesis) without decompression is considered medically necessary when ALL of the following criteria are met:

- Significant level of pain on a daily basis defined as **EITHER** of the following:
  - Visual Analog Scale (VAS) /Numeric Rating Scale (NRS) ≥ 7 on a daily basis
  - Severe, disabling, crippling, or incapacitating pain
- Clinically significant functional impairment (e.g. inability to perform household chores, prolonged standing or essential job functions)
- Less than clinically meaningful improvement with **EITHER** of the following for at least 3 consecutive months unless contraindicated, except for discogenic lower back/degenerative disc disease (see specific criteria below):
  - Prescription strength analgesics, steroids, and/or NSAIDs
  - Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician
- Absence of untreated, underlying psychological conditions/issues (e.g. depression, chronic pain syndrome, secondary gain, drug and alcohol abuse, etc.) as a contributor to chronic pain

- Documentation of nicotine-free status with **EITHER** of the following:
  - Patient is a never-smoker
  - Patient has refrained from smoking, use of tobacco products, and/or nicotine replacement therapy for at least 6 weeks prior to planned surgery as evidenced by blood cotinine lab results of ≤ 10 ng/mL
- Performed for **ANY** of the following:
  - Degenerative spondylolisthesis without spondylolysis when confirmatory imaging results show **EITHER** of the following:
    - Dynamic segmental instability documented by flexion-extension plain X-rays OR comparison of a supine and upright image, with a difference in translational alignment between vertebrae greater than 3 mm between views
    - Grade II or higher spondylolisthesis (i.e. instability)defined as at least 3 mm of anterolisthesis of the upper vertebra in relation to the lower vertebra, either isthmic (i.e. secondary to a posterior arch stress fracture) or degenerative type
  - Spondylolisthesis with spondylolysis when confirmatory imaging results show **ANY** of the following:
    - Multi-level spondylolysis on recent (within 6 months) plain X-rays
    - Symptomatic Grade 1 or 2 spondylolisthesis (anterolisthesis) with recent (within 6 months) plain X-rays supporting progression of anterolisthesis
    - Symptomatic Grade 3 or higher spondylolisthesis (anterolisthesis) demonstrated on recent (within 6 months) plain x-rays with 50% or more anterior slippage and plain X-rays supporting regression of anterolisthesis
    - Progressive spinal pain without confirmatory imaging of progression of spondylolisthesis
  - Discogenic lower back/degenerative disc disease when **ALL** of the following are met:
    - Presence of chronic, unremitting, discogenic axial lower back pain and associated disability secondary to single-level degenerative lumbar disc disease (DDD) for at least one year
    - Structured physician-supervised, multi-modal, nonoperative management of medical care with licensed healthcare professionals which includes regularly scheduled appointments, follow-up evaluation, and less than clinically meaningful improvement with at least **TWO** of the following for at least 12 consecutive months unless contraindicated:
      - Prescription strength analgesics, steroids, and/or NSAIDs
      - Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician
      - Epidural steroid injection(s)/selective nerve root block(s)
      - Facet joint injection(s)/medial branch block(s)/radiofrequency ablation(s)
    - Moderate to severe single-level disc degeneration has been confirmed on recent (within 6 months) plain X-rays and advanced diagnostic imaging studies (i.e., CT, MRI)
  - Initial disc herniation when **BOTH** of the following are met:

- This patient is a candidate for initial primary lumbar discectomy. Refer to **CMM-606: Initial Primary/Repeat Lumbar Microdiscectomy and Excision of Extradural Lesion other than Neoplasm**.
- **ANY** of the following is present:
  - Primary extraforaminal disc herniation at L5-S1, in which a far lateral approach is not feasible because of the presence of the iliac wings
  - Primary foraminal disc herniation for which facet resection is necessary to retrieve the disc, which will result in iatrogenic instability
  - Primary disc herniation in the lumbar spine that is at the level of the spinal cord (i.e., low lying conus medullaris)

- Recurrent disc herniation when **BOTH** of the following are met:
  - The patient is a candidate for repeat lumbar discectomy. Refer to **CMM-606.3: Repeat Lumbar Microdiscectomy at the Same Level**.
  - Confirmatory plain X-rays including neural structure compression demonstrated by the most recent (within 6 months) imaging **AND** plain X-ray evidence of anterolisthesis resulting in **EITHER** of the following:
    - Segmental instability with 3 mm or more of anterior translation displacement of the vertebra on the adjacent vertebra below
    - Grade II or higher spondylolisthesis (i.e., instability)
- Second or greater recurrent disc herniation when the patient is a candidate for repeat lumbar discectomy. Refer to **CMM-606.3: Repeat Lumbar Microdiscectomy at the Same Level**.
- Isthmic spondylolisthesis when congenital or acquired pars defect is documented by recent (within 6 months) imaging studies

CMM-609.3: Adjacent Segment Disease

Lumbar fusion (arthrodesis) for adjacent segment disease is considered medically necessary when ALL of the following are met:

- The patient meets criteria for lumbar fusion. Refer to: **CMM-609.2: Lumbar Fusion (Arthrodesis)**.
- The prior lumbar fusion (arthrodesis) procedure at an adjacent level was performed at least 6 months prior.
- Evidence of anterolisthesis on plain X-rays resulting in **BOTH** of the following:
  - Segmental instability with 3 mm or more of anterior translation displacement of the vertebra on the adjacent vertebra below
  - Grade II or higher spondylolisthesis (i.e., instability)
- Neural structure compression demonstrated by recent (within 6 months) plain X-rays
- Significant initial relief of symptoms following prior spinal fusion(s)

CMM-609.4: Failed Lumbar Disc Arthroplasty Implant

Lumbar discectomy and fusion following failed lumbar disc arthroplasty implant is considered medically necessary when EITHER of the following are met:

- Recent (within 6 months) post-operative plain X-rays show evidence of implant malposition or implant failure (e.g. subsidence, loosening, infection, dislocation/subluxation, vertebral body fracture, dislodgement)
- **ALL** of the following are met:
  - The patient meets criteria for lumbar fusion. Refer to: **CMM-609.2: Lumbar Fusion (Arthrodesis)**.
  - Recent (within 6 months) post-operative MRI /CT confirms evidence of neural structure compression (e.g. either retained disc material or a recurrent disc herniation)
  - Greater than 6 months since disc arthroplasty surgery

CMM-609.5: Repeat Lumbar Fusion (Arthrodesis) at the Same Level

Repeat lumbar fusion (arthrodesis) at the same level is considered medically necessary when EITHER of the following are met:

- Recent (within 6 months) post-operative plain X-rays show evidence of implant malposition or implant failure (e.g. migration, pedicle screw breakage, pedicle screw loosening, dislodged hooks, rod breakage, rod bending, rod loosening, loss of curve correction, decompensation, etc.)
- **ALL** of the following are met:
  - The patient meets criteria for lumbar fusion. Refer to: **CMM-609.2: Lumbar Fusion (Arthrodesis)**.
  - Recent (within 6 months) post-operative confirmatory imaging including **EITHER** of the following:
    - MRI /CT
    - CT or plain x-rays documenting pseudarthrosis
  - Greater than 6 months since the last fusion (arthrodesis) surgery

CMM-609.6: Non-Indications

Lumbar fusion (arthrodesis) is considered not medically necessary when the sole indication is ANY of the following:

- Disc herniation in the absence of **ANY** of the following:
  - Primary extraforaminal disc herniation at L5-S1, in which a far lateral approach is not feasible because of the presence of the iliac wings
  - Primary foraminal disc herniation for which facet resection is necessary to retrieve the disc, which will result in iatrogenic instability
  - Primary disc herniation in the lumbar spine that is at the level of the spinal cord (i.e., low lying conus medullaris)
- Multi-level degenerative disc disease without instability
- Neurocompressive pathology
- Facet joint disorders without instability
- Initial discectomy/laminectomy without instability
- An adjunct to primary decompression of central and/or lateral recess stenosis in the absence of instability, spondylolisthesis, or an actual or anticipated bony resection that will result in iatrogenic instability
- Spondylolysis without spondylolisthesis

ALL of the following devices/procedures are considered experimental, investigational, or unproven (not an all-inclusive list):

- Pre-sacral interbody fusion including AxiaLIF
- Minimally invasive surgical approaches using only indirect visualization (e.g. endoscopic fusion, percutaneous fusion (video imaging)
- Anterior interbody fusion or implantation of intervertebral body fusion devices using laparoscopic approach
- Device/implant not FDA approved
- Devices for disc annular repair
- Dynamic (intervertebral) stabilization (e.g. Dynesys, Stabilimax NZ)
- Interlaminar lumbar instrumented fusion (e.g. ILIF)
- Interspinous and interlaminar distraction devices
- Interspinous fixation/posterior non-pedicle supplemental fixation devices for spinal fusion (e.g. Affix, Aspen Spinous Process Fixation System, Coflex-F)
- Least invasive lumbar decompression interbody fusion (e.g. LINDIF)
- Isolated facet fusion, with or without instrumentation, including allograft bone graft substitutes used exclusively as stand-alone stabilization devices (e.g. TruFuse (any level), NuFix® (any level))
- Total facet arthroplasty

CMM-609.7: Procedure (CPT®) Codes

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code's inclusion on this list does not necessarily indicate prior authorization is required.

CPT®	Code Description/Definition
22533	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar
+22534	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional vertebral segment (List separately in addition to code for primary procedure)
22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar
+22585	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)
22586	Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace
22612	Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)
+22614	Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar
+22632	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure)
22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar
+22634	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression); each additional interspace and segment (List separately in addition to code for primary procedure)
22800	Arthrodesis, posterior, for spinal deformity, with or without cast; up to 6 vertebral segments
22802	Arthrodesis, posterior, for spinal deformity, with or without cast; 7 to 12 vertebral segments
22804	Arthrodesis, posterior, for spinal deformity, with or without cast; 13 or more vertebral segments
22808	Arthrodesis, anterior, for spinal deformity, with or without cast; 2 to 3 vertebral segments
22810	Arthrodesis, anterior, for spinal deformity, with or without cast; 4 to 7 vertebral segments
22812	Arthrodesis, anterior, for spinal deformity, with or without cast; 8 or more vertebral segments

+22840	Posterior non-segmental instrumentation (e.g. Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)
+22841	Internal spinal fixation by wiring of spinous processes (List separately in addition to code for primary procedure)
+22842	Posterior segmental instrumentation (e.g. pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure)
+22843	Posterior segmental instrumentation (e.g. pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral segments (List separately in addition to code for primary procedure)
+22844	Posterior segmental instrumentation (e.g. pedicle fixation, dual rods with multiple hooks and sublaminar wires); 13 or more vertebral segments (List separately in addition to code for primary procedure)
+22845	Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)
+22846	Anterior instrumentation; 4 to 7 vertebral segments (List separately in addition to code for primary procedure)
+22847	Anterior instrumentation; 8 of more vertebral segments (List separately in addition to code for primary procedure)
+22848	Pelvic fixation (attachment of caudal end of instrumentation to pelvic bony structures) other than sacrum (List separately in addition to code for primary procedure)
22849	Reinsertion of spinal fixation device
+22853	Insertion of interbody biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (List separately in addition to code for primary procedure)
+22854	Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)
+22859	Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)
0195T	Arthrodesis, pre-sacral interbody technique, disc space preparation, discectomy, without instrumentation, with image guidance, includes bone graft when performed; L5-S1 interspace
+0196T	Arthrodesis, pre-sacral interbody technique, disc space preparation, discectomy, without instrumentation, with image guidance, includes bone graft when performed; L4-L5 interspace (List separately in addition to code for primary procedure)
0202T	Posterior vertebral joint(s) arthroplasty (eg, facet joint[s] replacement), including facetectomy, laminectomy, foraminotomy, and vertebral column fixation, injection of bone cement, when performed, including fluoroscopy, single level, lumbar spine
0219T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; cervical

0220T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; thoracic
0221T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; lumbar
+0222T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; each additional vertebral segment (List separately in addition to code for primary procedure)
This list may not be all inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the health plan and is based on the individual's policy or benefit entitlement structure as well as claims processing rules.	

CMM-609.8: References

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CMM-610: Lumbar Total Disc Arthroplasty

CMM-610.1: General Guidelines

- The determination of medical necessity for the performance of lumbar total disc arthroplasty is always made on a case-by-case basis.
- For prior authorization requirements, see **CMM-600.1: Prior Authorization Requirements**.

CMM-610.2: Initial Primary Lumbar Total Disc Arthroplasty

Initial primary lumbar total disc arthroplasty is considered medically necessary when ALL of the following are met:

- An FDA approved implant is used in accordance with FDA requirements
- Presence of chronic, unremitting, discogenic axial lower back pain and associated disability secondary to single-level degenerative lumbar disc disease (DDD) for at least one year
- Age 18 to 60 years old
- Significant level of pain on a daily basis defined as **EITHER** of the following:
  - Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
  - Severe, disabling, crippling, or incapacitating pain
- Clinically significant functional impairment (e.g. inability to perform household chores, prolonged standing or essential job functions)
- Absence of unmanaged significant behavioral health disorders (e.g. major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse)
- Structured physician-supervised, multi-modal, nonoperative management of medical care with licensed healthcare professionals which includes **ALL** of the following:
  - Regularly scheduled appointments
  - Follow-up evaluation
  - Less than clinically meaningful improvement with **BOTH** of the following for at least 6 consecutive months unless contraindicated:
    - Prescription strength analgesics, steroids, and/or NSAIDs
    - Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician
- Moderate to severe single-level disc degeneration at L4-L5 or L5-S1 has been confirmed on recent (within 6 months) plain X-rays and advanced diagnostic imaging studies (i.e., CT, MRI)
- Absence of significant facet arthropathy at the operative level

CMM-610.3: Non-Indications

Lumbar artificial total disc arthroplasty is considered not medically necessary for ANY of the following:

- The revision of a failed lumbar artificial total disc arthroplasty
- The planned procedure includes the combined use of a prosthesis and spinal fusion (hybrid)
- Lumbar partial disc prosthetics
- Simultaneous multi-level implantation
- The implant will be inserted outside of the spinal motion segments approved by the FDA
- The patient has osteopenia or osteoporosis (T-score < -1.0)
- Above or below or in combination with a spinal fusion or other stabilizing type surgical procedure
- A lumbar disc prosthesis not approved by the FDA or for an FDA approved indication
- Degenerative disc disease above L4-L5
- Presence of unmanaged significant behavioral health disorders (e.g. major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse)
- Age less than 18 years or greater than 60
- As an adjunct to the treatment of primary central or far-lateral disc herniation
- There is evidence on imaging studies of **ANY** of the following:
  - Lytic or degenerative spondylolisthesis of Grade 2 or greater
  - Lumbar spinal stenosis
  - Pars interarticularis defect with either spondylolysis or isthmic spondylolisthesis
  - Scoliosis
  - Spinal fracture
  - Infection
  - Multi-level degenerative disc disease (2 or more levels) on a preoperative MRI and plain X-rays
  - Significant facet arthropathy at the operative level
  - Presence of tumor or active infection at the site of implantation
  - Lumbar nerve root compression or bony spinal stenosis
- Allergy or sensitivity to implant materials
- Isolated radicular compression syndromes especially due to lumbar disc herniation
- Involved vertebral endplate is dimensionally smaller than the approximate dimensions of the implant in anterior/posterior width and lateral width
- Clinically compromised vertebral bodies at the affected level due to current or past trauma

CMM-610.4: Procedure (CPT®) Codes

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code's inclusion on this list does not necessarily indicate prior authorization is required.	
CPT®	**Code Description/Definitions**
22857	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar
22862	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar
22865	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar
+0163T	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression),each additional interspace, lumbar (List separately in addition to code for primary procedure)
+0164T	Removal of total disc arthroplasty, (artificial disc), anterior approach, each additional interspace, lumbar (List separately in addition to code for primary procedure)
+0165T	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, lumbar (List separately in addition to code for primary procedure)
This list may not be all inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the health plan and is based on the individual's policy or benefit entitlement structure as well as claims processing rules	

CMM-610.5: References

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CMM-611: Sacroiliac Joint Fusion or Stabilization

CMM-611.1: General Guidelines

- The determination of medical necessity for the performance of sacroiliac joint fusion or stabilization is always made on a case-by-case basis.
- For prior authorization requirements, see **CMM-600.1: Prior Authorization Requirements**.

CMM-611.2: Minimally Invasive Sacroiliac Joint Fusion or Stabilization

Minimally invasive sacroiliac joint (SIJ) fusion using titanium triangular implants (SI BONE [iFUSE Implant™]) for the treatment of lumbopelvic pain originating from the SIJ is considered medically necessary when ALL of the following are met:

- Performed by an orthopedic surgeon or neurosurgeon with specific training and expertise in percutaneous sacroiliac joint fusion surgical techniques and regularly use image-guidance for placement of implants
- Presence of non-radiating lumbopelvic pain caudal to L5, buttock, hip, and/or groin pain without radiation into the leg(s) that impairs physical activities
- SIJ pain interfering with activities of daily living
- Patient localizes posterior pain to the posterior superior iliac spine (Fortin's point)
- Localized tenderness to palpation over the sacral sulcus and posterior SIJ
- Elicitation of typical pain on three (3) or more provocative physical examination maneuvers/tests that stress the SIJ:
  - Thigh thrust test
  - Compression test
  - Gaenslen's maneuver
  - Distraction test
  - FABER/Patrick's sign
  - Posterior provocation test
- Absence of localized tenderness to palpation of similar severity to palpation of the sacral sulcus and posterior SIJ over the greater trochanter, lumbar spine, and coccyx
- Diagnostic confirmation of the SIJ as a pain generator through ≥ 75% reduction in pain for the expected duration of effect of the anesthetic agent used upon two separate contrast-enhanced fluoroscopically or CT-guided intra-articular SIJ blocks using a local anesthetic performed
- SIJ pain without minimal clinically important difference (MCID) from a minimum of a consecutive six (6) months of conservative, non-surgical treatment including **ALL** of the following unless contraindicated:
  - Non-steroidal anti-inflammatory drugs (NSAIDs)
  - Prescription medication optimization
  - Activity modification
  - Physician supervised/prescribed active physical therapy (including home exercise program) targeting lumbopelvic (core) area

- Chiropractic care

- Absence of generalized pain behavior (e.g. somatoform disorder) or generalized pain disorders (e.g. fibromyalgia)
- Documentation of nicotine-free status with **EITHER** of the following:
  - Patient is a never-smoker
  - Patient has refrained from smoking, use of smokeless tobacco, and/or nicotine replacement therapy for at least 6 weeks prior to planned surgery as evidenced by blood cotinine lab results of ≤ 10 ng/mL
- Absence of unmanaged significant behavioral health disorders (e.g. major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse)
- Absence of alternative diagnoses that are a more likely cause of the patient's ongoing pain or disability
- Recent (within 6 months) diagnostic imaging studies that include **ALL** of the following:
  - Plain X-rays and/or cross sectional imaging (CT or MRI) that excludes the presence of destructive lesions (e.g. tumor, infection), acute fracture or inflammatory arthropathy that would not be properly addressed by SIJ fusion
  - Plain X-rays of the pelvis including the ipsilateral hip to evaluate potential concomitant hip pathology
  - Cross-sectional imaging (e.g. CT or MRI) of the lumbar spine to evaluate potential concomitant neural compression or other degenerative conditions

CMM-611.3: Open Sacroiliac Joint Fusion

Open sacroiliac joint (SIJ) fusion is considered medically necessary when ALL of the following are met:

- Recent (within 6 months) plain X-rays and/or cross-sectional imaging (CT or MRI) demonstrate localized SIJ pathology
- Documentation of nicotine-free status with **EITHER** of the following:
  - Patient is a never-smoker
  - Patient has refrained from smoking, use of smokeless tobacco products, and/or nicotine replacement therapy for at least 6 weeks prior to planned surgery as evidenced by blood cotinine lab results of ≤ 10 ng/mL
- **ANY** of the following:
  - Post-traumatic injury of the SIJ (e.g. following pelvic ring fracture)
  - As an adjunctive treatment for SIJ infection
  - Management of sacral tumor (e.g. partial sacrectomy)
  - When performed as part of a multisegmental long fusion constructs for the correction of spinal deformity (e.g. idiopathic scoliosis, neuromuscular scoliosis)
  - Failed prior percutaneous SIJ fusion

CMM-611.4: Non-Indications

- Minimally invasive or percutaneous SIJ fusion or stabilization using titanium triangular implants is considered **experimental, investigational, or unproven**, including, but not limited to **ANY** of the following:
  - Any case that does not fulfill **ALL** of the above criteria
  - Less than six months of SIJ pain and/or functional impairment
  - Failure to pursue conservative treatment of the SIJ unless contraindications are clearly documented
  - Systemic arthropathy (e.g. ankylosing spondylitis, psoriatic arthritis, rheumatoid arthritis)
  - Generalized pain behavior (e.g. somatoform disorder) or generalized pain disorder (e.g. fibromyalgia)
  - Presence of infection, tumor, or fracture
  - Acute traumatic instability of the SIJ
  - Presence of neural compression as seen on an MRI or CT that correlates with the patient's symptoms or other more likely source for the patient's pain
  - Any condition that would prevent insertion of the implants
  - Bilateral procedures on the same date of service
- The use of minimally invasive fusion products other than SI BONE (iFuse Implant™) System (e.g. Rialto SI Fusion System, SImmetry SI Joint Fusion System, Silex Sacroiliac Joint Fusion System, SiJoin Direct Posterior Fusion, Samba-Screw System, SI-LOK Sacroiliac Joint Fixation System) for minimally invasive SIJ fusion is considered **experimental, investigational or unproven**.
- Open sacroiliac joint (SIJ) fusion is considered **experimental, investigational, or unproven**, for **ANY** of the following indications:
  - Mechanical low back pain
  - Sacroiliac joint syndrome
  - Degenerative sacroiliac joint
  - Radicular pain syndromes

CMM-611.5: Procedure (CPT®) Codes

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code's inclusion on this list does not necessarily indicate prior authorization is required.

CPT®	Code Description/Definitions
27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device
27280	Arthrodesis, open, sacroiliac joint, including obtaining bone graft, including instrumentation, when performed

This list may not be all inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the health plan and is based on the individual's policy or benefit entitlement structure as well as claims processing rules

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CMM-612: Grafts

CMM-612.1: General Guidelines

- The determination of medical necessity for grafts (orthobiologics) is always made on a case-by-case basis.
- For prior authorization requirements, see **CMM-600.1: Prior Authorization Requirements**.
- Definition/technique for bone marrow aspirate concentrate (see **CMM-612.3: Bone Marrow Aspirate Concentrate** for criteria):
  - A bone marrow aspirate concentrate (BMAC) is intended as a high concentration of viable connective tissue osteoprogenitor cells. The aspiration technique requires that no more than 2 mL of blood is aspirated from any given area in the iliac crest to avoid dilution with peripheral blood. The aspiration of 80 to 100 cc of marrow from the iliac crest is performed using a sequential technique (Muschler) through a small incision made over the iliac crest through different trajectories until the desired amount is obtained. A single aspiration instead of using a sequential technique produces the lowest yield of viable cells. The aspirate is then transferred to the concentrating device (centrifuge) that removes the red blood cell fractions and plasma. The BMAC can be admixed to the osteoconductive biocompatible substrates of choice e.g. collagen sponges, hydroxyapatite (HA) substrates and other porous ceramics as well as particulate demineralized bone matrix (DBM) to fabricate composite hybrid grafts.

CMM-612.2: Recombinant Human Bone Morphogenetic Protein (rhBMP-2) (InFuse®)

The clinical criteria of this policy addresses the scope and clinical indications for Recombinant Human Bone Morphogenetic Protein – 2 (rhBMP-2) (InFuse®) in spinal fusion surgeries only and not for other indications for its use in the appendicular skeleton (e.g. tibial fracture non-union repair surgery). These criteria are developed to manage patients very unlikely to fuse without rhBMP. Patients very likely to fuse without rhBMP include most pediatric patients, healthy patients undergoing one level lumbar fusion procedures and undergoing routine anterior and posterior cervical fusions.

- Recombinant human bone morphogenetic protein – 2 (rhBMP-2) (InFuse®) is considered **medically necessary** for a stand alone anterior lumbar interbody fusion (ALIF) for all patients except males with a strong reproductive priority.
- Recombinant human bone morphogenetic protein – 2 (rhBMP-2) (InFuse®) is considered **medically necessary** for posterolateral lumbar fusion and posterior lumbar interbody fusion (PLIF and TLIF) when **ONE or MORE** of the following conditions at high risk for fusion failure is present:
  - Revision spinal fusion surgery for pseudarthrosis following one or more previous failed spinal fusion surgery(ies)
  - Spinal fusion surgery in a compromised graft bed (e.g. prior radiation therapy)
  - Thoracolumbar fusion for correction of spinal deformity performed at more than one level
  - Multilevel spinal fusion surgeries (> 3 spinal motion segments)

- Long posterior fusions to the sacrum in adults patients undergoing correction or stabilization of spinal deformity
- Single level anterior interbody lumbar or lumbosacral fusion (ALIF) using an FDA approved fusion device when there is Grade III or greater spondylolisthesis.
- Metabolic or other conditions when traditional, autogenous bone grafting has a high risk of failure (**ONE or MORE** of the following):
  - Current smoker
  - Insulin diabetic with poor glycemic control
  - Chronic renal disease
  - Alcohol Use Disorder (AUD)
  - Corticosteroid dependence
  - Pediatric patients with neuromuscular scoliosis or occipitocervical pathology
- Autogenous bone graft is either not available, is inadequate volume, or of poor quality to be useful (**ONE or MORE** of the following):
  - Rheumatoid arthritis
  - Osteoporosis
  - Trauma patients with concomitant pelvic injury
  - Patients at high risk for post-harvest iliac crest fracture

- Recombinant human bone morphogenetic protein – 2 (rhBMP-2) (InFuse®) is considered **not medically necessary** for **ANY** of the following:
  - Skeletally immature patients unless there is a high risk for fusion failure
  - Planned use of grafting in the vicinity of a resected or extant neoplasm
  - Known contraindications including pregnancy, hypersensitivity/allergy, infection, spinal malignancy
  - Routine anterior and/or posterior cervical fusion surgery other than in pediatric patients with a high risk of fusion failure
  - Routine pediatric spine fusion procedures including correction of adolescent idiopathic scoliosis
  - Single level anterior interbody lumbar or lumbo-sacral fusion (ALIF) using an FDA approved fusion device when there is Grade II or less spondylolisthesis

CMM-612.3: Bone Marrow Aspirate Concentrate (BMAC)

- Bone marrow aspirate concentrate (BMAC) is considered **medically necessary** for hybrid or composite grafting (combined osteoinductive and osteoconductive) including autologous corticocancellous iliac crest bone graft (ICBG) for postero-lateral lumbar spinal fusion surgery (spondylodesis) with or without spinal instrumentation.

- Bone marrow aspirate concentrate (BMAC) is considered **experimental, investigational, or unproven** for **ALL** of the following:
  - BMAC combined with allograft or synthetic scaffold as a substitute for autologous bone graft for spinal fusion surgery (spondylodesis) with or without spinal instrumentation
  - Application to cervical/thoracic spinal fusion surgery with or without instrumentation
  - Anterior spinal fusion surgery with or without instrumentation

- Application to spinal decompression without fusion
- Disc arthroplasty surgery
- Use of lumbar interspinous devices
- Obtaining BMAC without using the sequential technique as outlined
- Use of unfractionated BMAC
- Infection (e.g. discitis, epidural abscess, osteomyelitis)
- Primary or metastatic neoplastic disease of the spine

CMM-612.4: Bone Graft Substitutes

ALL of the following bone graft substitutes for the enhancement of bone healing is considered experimental, investigational, or unproven:

- rhBMP-7 (i.e., OP–1™)
- INFUSE/MASTERGRAFT™ Posterolateral Revision Device
- Human amniotic membrane bone graft substitute
- Cell-based substitutes other than a bone marrow aspirate (e.g. mesenchymal stem cell therapy, Osteocel®, ViviGen®, Trinity®) when used to enhance bone healing
- Human growth factors (e.g. fibroblast growth factor, insulin-like growth) when used to enhance bone healing
- Platelet rich plasma (e.g. autologous platelet derived growth factor) when used to enhance bone healing
- Allograft bone graft substitutes used exclusively as stand-alone stabilization devices for fusion (e.g. TruFuse® for isolated facet fusion, NuFix™ for isolated facet fusion, BacFast® HD for isolated facet fusion)
- Bone graft substitutes used to reduce donor site morbidity (e.g. iliac crest donor site reconstruction)
- Ceramic-based products (e.g. b-TCP)
- OptiMesh® deployable grafting system

CMM-612.5: Procedure (CPT®) Codes

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code's inclusion on this list does not necessarily indicate prior authorization is required.

CPT®	Code Description/Definition
+20930	Allograft, morselized, or placement of osteopromotive material, for spine surgery only (List separately in addition to code for primary procedure
+20931	Allograft, structural, for spine surgery only (List separately in addition to code for primary procedure)
+20936	Auto graft for spine surgery only (includes harvesting the graft); local (e.g. ribs, spinous process, or laminar fragments) obtained from same incision (List separately in addition to code for primary procedure)
+20937	Auto graft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision) (List separately in addition to code for primary procedure)
+20938	Auto graft for spine surgery only (includes harvesting the graft); structural, bicortical or tricortical (through separate skin or fascial incision) (List separately in addition to code for primary procedure)
+20939	Bone marrow aspiration for bone grafting, spine surgery only, through separate skin or fascial incision (List separately in addition to code for primary procedure).

This list may not be all inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the health plan and is based on the individual's policy or benefit entitlement structure as well as claims processing rules.

CMM-612.6: References

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