



CLINICAL GUIDELINES

Spine Surgery Guidelines

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Spine Surgery Guidelines

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CMM-600: Preface to Spine Surgery Guidelines

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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) 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
 - Review of clinically meaningful improvement will be assessed for each treatment. This is a global assessment showing at least 50% improvement.
 - ◆ Written reports/interpretations of the most recent advanced diagnostic imaging studies (e.g., CT, MRI, Myelography) by an independent radiologist whose report shall supersede any discrepancies (when present) in interpretation
 - 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: flexion-extension radiographs based upon indications for instability and/or other plain radiographs 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 nonsmoker
 - Patient has refrained from smoking for at least 6 weeks prior to planned surgery as evidenced by 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.

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 2018 NCQA standards for utilization management and is as follows:
 - ◆ A request for medical care or services when application of the time frame for making routine or non-life threatening care determinations:
 - 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-601: Anterior Cervical Discectomy and Fusion

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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 in lieu of provider-directed non-surgical management and/or proof of smoking cessation. Confirmatory imaging studies are required.
- 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)
 - ◆ 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 radiographs 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) radiographs 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 on a Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
 - Unrelenting 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)
 - Unrelenting 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 nonsmoker
 - Patient has refrained from smoking for at least 6 weeks prior to planned surgery as evidenced by 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 spinal cord compression
 - MRI/CT identifies stenosis with or without myelomalacia

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 pseudoarthrosis documented by confirmatory imaging that is unresponsive to 6 months of non-surgical treatment
- Malposition or failure of the implant/structural bone graft
- Recent (within 3 months) radiographs 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 on a Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
 - 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 prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks unless contraindicated
- Recent (within 3 months) 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 nonsmoker
 - Patient has refrained from smoking for at least 6 weeks prior to planned surgery as evidenced by 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 on a Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
 - 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 3 months) confirmatory imaging including **EITHER** of the following that is concordant with the patient's symptoms and physical examination findings:
 - MRI with or without contrast/CT myelogram confirms evidence of neural structure compression (e.g., either retained disc material or a recurrent disc herniation)

- CT documenting pseudoarthrosis, no less than 6 months after initial fusion
- Documentation of nicotine-free status including **EITHER** of the following:
 - Patient is a nonsmoker
 - Patient has refrained from smoking for at least 6 weeks prior to planned surgery as evidenced by 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 3 months) confirmatory MRI/CT findings including **ANY** of the following:
 - MRI with or without contrast/CT myelogram confirms evidence of neural structure compression
 - MRI with or without contrast/CT myelogram identifies stenosis with or without myelomalacia
 - CT scan documenting pseudoarthrosis, 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) radiographs of the cervical spine including flexion/extension lateral views and advanced diagnostic imaging demonstrating successful decompression and/or fusion at the adjacent level
- 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 on a Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
 - 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 months
 - Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 months
 - 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 nonsmoker
 - Patient has refrained from smoking for at least 6 weeks prior to planned surgery as evidenced by 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 spinal cord compression
 - MRI/CT identifies stenosis with or without myelomalacia.

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 3 months) 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 on a Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
 - 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 prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks unless contraindicated
 - Recent (within 3 months) 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 nonsmoker

- Patient has refrained from smoking for at least 6 weeks prior to planned surgery as evidenced by 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 on a Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
 - 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 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 3 months) 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 nonsmoker
 - Patient has refrained from smoking for at least 6 weeks prior to planned surgery as evidenced by 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 3 months) MRI/CT findings that are concordant with the patient's symptoms or physical examination findings including **ANY** of the following:
 - MRI/CT demonstrates spinal cord compression
 - MRI/CT identifies stenosis with or without myelomalacia.

CMM-601.6: Non-Indications

- Anterior cervical discectomy and fusion (ACDF) is **not medically necessary** for **EITHER** of the following:
 - ◆ Chronic non-specific cervical pain
 - ◆ The sole indication of degenerative disc disease

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, osteophyctomy and decompression of spinal cord and/or nerve roots; cervical below C2 |
| +22552 | Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophyctomy 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) |
| 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 |
| +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

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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 in lieu of provider-directed non-surgical management. Confirmatory imaging studies are required.
- Documentation of severe debilitating pain and/or dysfunction to the point of being incapacitated is considered an urgent/emergent condition for cervical total disc arthroplasty.

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
 - ProDisc™-C
 - BRYAN® 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 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)

- 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 on a Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
 - 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
 - ◆ 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 spinal cord compression
 - MRI/CT identifies stenosis with or without myelomalacia

CMM-602.3: Failed Cervical Total Disc Arthroplasty Implant

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

- Recent (within 3 months) imaging studies of the cervical spine including flexion/extension lateral views 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 on a Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
 - 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 prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks unless contraindicated
 - Recent (within 3 months) 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 on a Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
 - 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 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 3 months) 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 3 months) MRI/CT findings that are concordant with the patient's symptoms or physical examination findings including **ANY** of the following:
 - MRI/CT demonstrates spinal cord compression
 - MRI/CT identifies stenosis with or without myelomalacia.

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:

- Recent (within 6 months) imaging studies of the cervical spine including flexion/extension lateral views demonstrating successful decompression and/or fusion at the adjacent level
- 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)
- The patient is a candidate for single-level anterior cervical decompression(s) and interbody fusion(s)
- 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 on a Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
 - 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 months
 - Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 months
 - 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 spinal cord compression
 - MRI/CT identifies stenosis with or without myelomalacia.

CMM-602.5: Non-Indications

- Cervical disc arthroplasty for degenerative disc disease as the sole indication is considered **not medically necessary**.
- Cervical disc arthroplasty is considered **experimental, investigational, or unproven** when **ANY** of the following are present:
 - ◆ The planned procedure includes the combined use of a prosthesis and spinal fusion (hybrid construct)
 - ◆ Patient is under age 18 or over age 60
 - ◆ The patient had a prior fusion at an adjacent cervical level (hybrid construct)
 - ◆ The patient had prior surgery at the treated level
 - ◆ Osteoporosis 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 \leq -1.0 (Osteopenia)
 - ◆ Allergy or sensitivity to titanium, aluminum or vanadium
 - ◆ Neck or arm pain of unknown etiology
 - ◆ Absence of neck and/or arm pain
 - ◆ Progressive neurological deficit(s) or deterioration
 - ◆ Active systemic infection or localized infection at the surgical site
 - ◆ 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 radiographs, 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
- 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 osteophylectomy 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 osteophylectomy 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)

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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) electrical bone growth stimulation may be considered **medically necessary** for lumbar/lumbosacral spinal fusion surgery in patients at high risk for pseudoarthrosis with **ONE or MORE** of the following risk factors for fusion failure:
 - ◆ 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 lumbar/lumbosacral 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
 - ◆ Spinal malignancy
- Noninvasive electrical bone growth stimulation is considered **medically necessary** as a treatment for patients with failed lumbar/lumbosacral spinal fusion when **BOTH** of the following are met:
 - ◆ A minimum of 6 months has passed since the date of the original surgery
 - ◆ Serial radiographs 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.

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
 - ◆ Adjunct to primary cervical/thoracic spine fusion surgery
 - ◆ Failed cervical/thoracic spine fusion surgery
 - ◆ Failed cervical or lumbar disc arthroplasty
- 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

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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 in lieu of provider-directed non-surgical management and/or proof of smoking cessation. Confirmatory imaging studies are required.
- 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 \leq 10 mm)
 - ◆ Documentation of progressive neurological deficit on two separate physical examinations
 - ◆ Epidural hematoma
 - ◆ Infection (e.g., discitis, epidural abscess, osteomyelitis)
 - ◆ 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

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) radiographs 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 on a Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
 - 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, unless request is for decompression only:
 - Patient is a nonsmoker
 - Patient has refrained from smoking for at least 6 weeks prior to planned surgery as evidenced by 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 spinal cord compression
 - MRI/CT identifies stenosis with or without myelomalacia
- ◆ 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 pseudoarthrosis 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 radiographs
 - 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 radiographic views
 - ◆ 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 nonsmoker
 - ◆ Cotinine level lab results showing that the patient has refrained from smoking for at least 6 weeks prior to planned surgery

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 3 months) radiographic plain film or CT evidence of implant/instrumentation or structural bone graft malposition or failure **OR** when **ALL** of the following criteria are met:

- Recent (within 3 months) MRI with or without contrast/CT myelogram confirms evidence of neural structure compression (e.g., either retained disc material or a recurrent disc herniation)
- 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) radiographs 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 radiographs

- ◆ 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 radiographic views
- 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 on a Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
 - 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, unless request is for decompression only:
 - Patient is a nonsmoker
 - Patient has refrained from smoking for at least 6 weeks prior to planned surgery as evidenced by 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 spinal cord compression
 - MRI/CT identifies stenosis with or without myelomalacia

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 3 months) 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 3 months) CT myelogram/MRI with or without contrast 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 on a Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
 - 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)
 - Documentation of nicotine-free status with **EITHER** of the following, unless request is for decompression only:
 - Patient is a nonsmoker
 - Patient has refrained from smoking for at least 6 weeks prior to planned surgery as evidenced by 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

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

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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 in lieu of provider-directed non-surgical management. Confirmatory imaging studies are required. Urgent/emergent conditions for cervical microdiscectomy include **ANY** of the following:
 - ◆ Acute 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 on a Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
 - 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 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 spinal cord compression
 - MRI/CT identifies stenosis with or without myelomalacia

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 3 months) MRI with or without contrast/CT myelogram 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 on a Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
 - 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)
 - ◆ 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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14. Mummaneni PV, et al. Preoperative patient selection with magnetic resonance imaging, computed tomography, and electroencephalography: does the test predict outcome after cervical surgery? *Journal of Neurosurgery: Spine* 2009;11(2):119-29.
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CMM-606: Lumbar Microdiscectomy (Laminotomy, Laminectomy, or Hemilaminectomy)

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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 in lieu of provider-directed non-surgical management. Confirmatory imaging studies are required.
- Urgent/emergent conditions for lumbar microdiscectomy and excision of extradural lesion other than neoplasm include **ANY** of the following:
 - ◆ 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 on a Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
 - ◆ 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 MRI without or without and with contrast/CT myelogram (within 3 months) 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

- 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 on a Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
 - ◆ 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 | Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophylectomy; lumbar, single interspace |
| +S2351 | Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophylectomy; 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

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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 in lieu of provider-directed non-surgical management. Confirmatory imaging studies are required.
- 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 3 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:
 - ◆ Level of pain on a Visual Analog Scale (VAS)/Number Rating Scale (NRS) ≥ 7 on a daily basis
 - ◆ 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 3 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 **ANY** 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
 - ◆ Presence of painful metastases to areas other than the spine, spinal cord compression, primary bone and osteoblastic tumors, solitary plasmacytomas
 - ◆ Severe cardiopulmonary disease
 - ◆ Lack of neurological backup for emergency decompression in the event a neurological deficit develops during the injection of PMMA
 - ◆ 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)
 - ◆ Percutaneous mechanical vertebral augmentation using any device other than a balloon device, including, but not limited to: use of the Kiva system and radiofrequency-assisted vertebral augmentation
- Spineoplasty (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

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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 in lieu of provider-directed non-surgical management. Confirmatory imaging studies are required.
- 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 on a Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
 - ◆ 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) MRI/CT
 - Less than clinically meaningful improvement from epidural steroid injection(s)/selective nerve root block(s) unless contraindicated
 - ◆ Spondylolisthesis with neurogenic claudication symptoms or radicular pain from lateral recess, or foraminal stenosis associated with listhesis demonstrated on plain x-rays
- Less than clinically meaningful improvement with **EITHER** 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) 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 3 months) post-operative MRI without or without and with contrast/CT myelogram confirms radiographic evidence of neural structure compression
- Greater than 12 weeks since last decompression surgery
- Initial relief of symptoms following previous decompression procedure at the same level(s)
- 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 on a Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
 - ◆ 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) MRI/CT
 - Less than clinically meaningful improvement from epidural steroid injection(s)/selective nerve root block(s) unless contraindicated
 - ◆ Spondylolisthesis with neurogenic claudication symptoms or radicular pain from lateral recess, or foraminal stenosis associated with
 - listhesis demonstrated on plain x-rays
- Severe and disabling symptoms or less than clinically meaningful improvement with **EITHER** 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

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
- 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, Superior 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) |
| 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)

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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 in lieu of provider-directed non-surgical management and/or proof of smoking cessation. Confirmatory imaging studies are required.
- 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 nonsmoker
 - ◆ Patient has refrained from smoking for at least 6 weeks prior to planned surgery as evidenced by 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 Visual Analog Scale (VAS) ≥ 7 on a daily basis
- Clinically significant functional impairment (e.g., inability to perform household chores, prolonged standing or essential job functions)
- Less than clinically meaningful improvement **EITHER** of the following for at least 3 consecutive months unless contraindicated:
- ◆ Prescription strength analgesics, steroids, and/or NSAIDs
 - ◆ Provider-directed 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 nonsmoker
 - ◆ Patient has refrained from smoking for at least 6 weeks prior to planned surgery as evidenced by 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 radiographs 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) radiographic studies

- Symptomatic Grade 1 or 2 spondylolisthesis (anterolisthesis) with recent (within 6 months) radiographic documentation 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 radiographic documentation 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
 - Age 18 to 60 years old
 - 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 at L4-L5 or L5-S1 has been confirmed on recent (within 6 months) plain radiographs 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 radiographic imaging including neural structure compression demonstrated by the most recent (within 6 months) imaging **AND** radiographic 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)
- ◆ 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)**.
- Radiographic evidence of anterolisthesis 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) radiographic imaging
- Significant initial relief of symptoms following prior spinal fusion(s)
- 6 or more months since the previous fusion

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) radiographic (plain film) 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) MRI without contrast or without and with contrast/CT myelogram confirms evidence of neural structure compression (e.g., either retained disc material or a recurrent disc herniation)
 - ◆ Significant initial relief of prior symptoms following prior surgery
 - ◆ 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) radiographic (plain film) evidence of implant malposition or implant failure (e.g., pedicle screw breakage, screw loosening, curve/correction decompensation)
- **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) confirmatory imaging including **EITHER** of the following:
 - MRI with or without and with contrast/CT myelogram
 - CT or plain x-rays documenting pseudoarthrosis
 - ◆ Significant initial relief of prior symptoms following prior surgery
 - ◆ 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
- Spinal stenosis without instability
- An adjunct to primary decompression of central, foraminal, and/or lateral recess stenosis in the absence of instability

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)
- Minimally invasive lumbar decompression (MILD)
- Minimally invasive thoracic discectomy for the treatment of axial spinal pain
- Percutaneous endoscopic discectomy
- 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) |

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| 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 or 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) |

| | |
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| +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

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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 Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7 on a daily basis
- 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 radiographs 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 peroperative MRI and plain radiographs
 - ◆ Significant facet arthropathy at the operated 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 this 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 |
| +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) |
| 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 |
| 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-611: Sacroiliac Joint Fusion or Stabilization

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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 at least an 80% 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 at a minimum of two weeks apart
- Confirmation of the SIJ as a pain generator through at least a 50% reduction in pain for a minimum of two weeks following one contrast-enhanced fluoroscopically or CT-guided intra-articular SIJ injection using a corticosteroid
- 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 nonsmoker
 - ◆ Patient has refrained from smoking for at least 6 weeks prior to planned surgery as evidenced by 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 radiographs 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 radiographs 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 radiographs 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 nonsmoker
 - ◆ Patient has refrained from smoking for at least 6 weeks prior to planned surgery as evidenced by 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)

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**, including, but not limited to **ANY** of the following:
 - ◆ 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

CMM-611.6: References

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CMM-612: Grafts

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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®)

- Recombinant human bone morphogenetic protein rhBMP-2 (InFuse®) is considered **medically necessary** for **ANY** of the following:
 - ◆ Approved lumbar spine fusion (stand-alone anterior lumbar interbody fusion [ALIF], posterolateral lumbar fusion, posterior lumbar interbody fusion [PLIF and TLIF])
 - ◆ High risk of fusion failure due to the presence of **ONE or MORE** of the following:
 - One or more previous failed spinal fusion(s) with pseudoarthrosis
 - Grade III or worse spondylolisthesis
 - Thoracolumbar fusion to be performed at more than one level
 - Current smoker
 - Diabetes
 - Renal disease
 - Alcoholism
 - Osteoporosis
 - Steroid use
 - Compromised graft bed (e.g., prior radiation therapy)
 - Autogenous bone graft is not available or of poor quality (e.g., rheumatoid arthritis patients)
 - Pediatric patients at very high risk of fusion failure (e.g., neuromuscular scoliosis, occipitocervical pathology)

- ◆ Autologous bone and bone marrow harvest are not feasible or are not expected to promote fusion
- ◆ In combination with FDA-approved fusion device for a single-level anterior interbody lumbar or lumbo-sacral fusion (e.g., ALIF) surgery for no more than Grade III spondylolisthesis at the involved level
- Recombinant human bone morphogenetic protein rhBMP-2 (InFuse®) is considered **experimental, investigational, or unproven** for **ALL** of the following:
 - ◆ Skeletally immature patient
 - ◆ Planned use of grafting in the vicinity of a resected or extant tumor
 - ◆ Known contraindications (e.g., pregnancy, hypersensitivity/allergy, infection, spinal malignancy)
 - ◆ Treatment of the cervical or thoracic spine other than in pediatric patients at very high risk for fusion failure (e.g., neuromuscular scoliosis occipitocervical pathology)
 - ◆ Lumbar spine surgery via posterior approach

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 posterolateral 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) 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 lamina 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. | |

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